Farmer's Drugs

Record of Vaccine Administration

Phone: 856-5761 Fax: 856-8382

Patient Name: ______________________ Birth Date: ____________

Address: ______________________ Phone: ____________

City: ______________ State: ________ Zip: ________

Primary Care Physician: ______________________ Dr. Fax: ____________

Influenza

	YES	NO
1. Are you sick today? Have you had any COVID-19 symptoms in the last 10 days?	____	____
2. Do you have allergies to medications, food or any vaccine? (Examples: Eggs, Bovine, Protein, Gelatin, Gentamicin, Polymyxin, Neomycin, Phenol or Thimersal)	____	____
3. Have you ever had a serious reaction to an influenza vaccine or any other vaccine?	____	____
4. Have ever had a seizure, brain, or other nervous system disorder?	____	____
5 For women: Are you pregnant or considering becoming pregnant in the next month?	____	____
6. Do you have cancer, leukemia, HIV/AIDS or any other immune system problem?	____	____
7. Do you take cortisone, prednisone, or other steroids, anticancer drugs or other medications that affect your immune system?	____	____
8. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, diabetes, anemia or blood disorder?	____	____

I certify that I am either at least 18 yrs of age, or the parent or legal guardian of the patient requesting vaccination. Further, I hereby give consent to Farmer's Drugs & Gifts to administer the vaccine requested above. I understand that it is not possible to predict all side effects or complications associated with receiving vaccines. I understand the risks and benefits associated with the requested vaccine and have received and read or had explained to me a Vaccine Information Sheet pertaining to the requested vaccine. I also acknowledge that I have been given the opportunity to ask questions and such questions were answered satisfactorily.

I acknowledge that I have been asked to remain near the vaccination area for 15 minutes after administration for observation and I release Farmer's Drugs from any liabilities or claims if I choose otherwise. I authorize Farmer's Drugs & Gifts to release any medical or other pertinent information to my other health care providers, Medicare, Medicaid, or other third party payer necessary to effectuate care or payment of authorized benefits and request that payment be made on my behalf to Farmer's Drugs as applicable, with respect to the above requested vaccine. I authorize Farmer's Drugs & Gifts to disclose my health information relating to the administration of this vaccine to the Louisiana Office of Public Health registry (LINKS).

Signature:______________________ **Date:**____________

Physician Chart Record: Date of Administration: ____________

	Vaccine	Brand	Mfr	Lot	Exp	Dose	Route	Site	VIS date
1.	____	____	____	____	____	0.5 ml	IM	R / L Arm	08/06/2021
2.	____	____	____	____	____	0.5 ml	IM	R / L Arm	08/06/2021

Administered by: ______________________

We appreciate the opportunity to serve your patients. Feel free to contact us for any assistance.

INSURANCE INFORMATION

ID# ____________ RX Bin: ________ Rx Grp: ________ RX PCN: ________