



**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**

	<b>YES</b>	<b>NO</b>
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	08/15/2019
2. _____	_____	_____	_____	_____	0.5 ml	IM	R / L Arm	08/15/2019

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: \_\_\_\_\_