Vaccine Registration and Information

Name:	Date of Birth & Age:
Street Address:	Primary Physician:
City, State, Zip Code:	Physician Phone #:
Phone #:	
Allergies:	Date of Last Physical:

I would like to be protected against: (please circle)

- ☐ Influenza (Flu)
- ☐ Pneumococal
- ☐ High Dose Influenza (Flu)(**65+ only**)
- ☐ Shingles (Zostavax®)
- ☐ Tetanus/Diptheria/Whooping Cough
- ☐ Other:_____

	Yes	No
1. Are you sick today or have a fever?	☐	☐
2. Have you ever fainted, felt dizzy or had a serious reaction after receiving a vaccine?	☐	☐
3. Are you pregnant or is there a chance you could be pregnant?	☐	☐
4. Did you receive the flu vaccine last year? (Date:)	☐	☐
5. Do you have a brain or nerve disorder such as Guillain-Barré or have you developed such disorder after receiving a vaccine?	☐	☐
6. Have you ever had a seizure or been diagnosed with seizure disorder?	☐	☐
7. Have you had any antiviral treatment within the past 24 hours?	☐	☐
8. Do you or anyone in your household take prednisone, any steroid, anticancer drugs, or have radiation or x-ray treatment?	☐	☐
9. Do you or anyone in your household have cancer, leukemia, HIV/AIDS, care for a child, or have any problem that could affect your immune system?	☐	☐
10. Are you allergic to any of the following: eggs, yeast, streptomycin, neomycin, thimerosal, any vaccine or vaccine component?	☐	☐

"I have read or have had explained to me written information about the vaccine listed below. I have also received a written VIS form concerning the vaccine that I wish to receive. I have had an opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine being administered and authorize the administration of the vaccine to me or to the person named below for whom I am authorized to make this decision. I understand that I have been advised to stay at least 15 minutes after vaccine administration. If I leave prior to 15 minutes, I am leaving against pharmacist and medical advice. I authorize Barney's Pharmacy to contact my physician regarding the vaccine(s) I am receiving. I also authorize that I will give consent to blood draws in the case that a Barney's employee is exposed to blood products in which the results will only be provided to you as a patient, the employee, and the employee's healthcare provider."

Signature:_____ Date:_____

Vaccine Registration and Information

Please list all medical conditions and/or current illnesses:

1. 6.
2. 7.
3. 8.
4. 9.
5. 10.

Please list all medications (prescription and over the counter) that you are currently taking:

1. 6.
2. 7.
3. 8.
4. 9.
5. 10.

	Yes	No
Have you ever received a shingles vaccine?	☐	☐
Have you ever received a meningitis vaccine?	☐	☐
Have you had a pneumococcal vaccine within the past 5 years?	☐	☐

Pharmacist Use Only			
Vaccine Name Manufacturer	Lot Number Expiration	Site and Route of Vaccine IM Sub-Q Deltoid L R	Administered By (Name/Title) and Date
Gave VIS Form [ ]		Entered Information into GRITS [ ]	Form faxed to MD [ ]

Pharmacist Use Only			
Vaccine Name Manufacturer	Lot Number Expiration	Site and Route of Vaccine IM Sub-Q Deltoid L R	Administered By (Name/Title) and Date
Gave VIS Form [ ]		Entered Information into GRITS [ ]	Form faxed to MD [ ]