



# Vaccine Registration and Information

Barney's Pharmacy · 706-798-5645  
2604 Peach Orchard Road·Augusta, Ga 30906

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

**I would like to be protected against:** (please circle) Flu Flu 65+  Pneumonia Shingles Hepatitis A  
Hepatitis B Meningitis Tetanus Whooping Cough Measles/Mumps/Rubella (MMR)\*Varicella\*

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

*"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: \_\_\_\_\_

List medical conditions and/or current illnesses:

List current medications (Prescription and OTC):

- |  |                    |
|--|--------------------|
| Have you ever received a shingles vaccine?                   | YES/NO/DO NOT KNOW |
| Have you ever received a meningitis vaccine?                 | YES/NO/DO NOT KNOW |
| Have you had a pneumococcal vaccine within the past 5 years? | YES/NO/DO NOT KNOW |
| Have you received any other vaccine(s) in the last 4 weeks?  | YES/NO/DO NOT KNOW |

**Emergency Contact** Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_



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PROVIDER NOTICE OF IMMUNIZATION

Physician and/or Healthcare Provider:

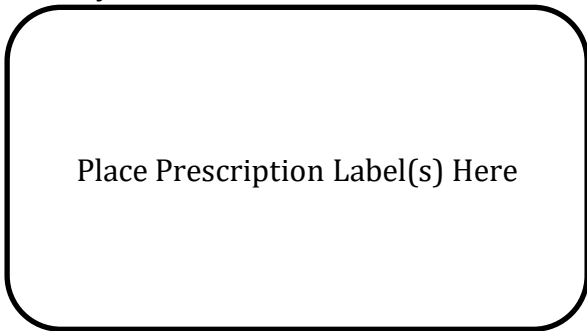
\_\_\_\_\_

Fax Number: (    )    -   

Our mutual patient \_\_\_\_\_ DOB \_\_\_\_\_ recently received the below listed immunization(s) at Barney's Pharmacy. If you have any questions or concerns, please contact a pharmacist at Barney's Pharmacy.

Regards,

Barney's Pharmacist



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

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