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?	☐	☐
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:_____

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

Place Prescription Label(s) Here

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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