# IMMUNIZATION FORM

**Date: _______/_______/_________**

**VACCINE REQUESTED: ☐ Hepatitis B ☐ IPV (Polio) ☐ MenACWY ☐ MMR ☐ Tdap (Tetanus)**

**Patient Name:_____________________________________________ Date of Birth:_____/_____/_______ Age: ________________**

**Address: ________________________________________ City: ____________________________ State: _______ Zip:__________**

**Phone Number:_________________________ Gender: Male ☐ Female ☐ Weight (ONLY IF LESS THAN 110 lbs):____________**

**Drug Allergies: ___________________________________________________________________________ ☐ None Known**

| **The following questions will help us to determine which vaccines may be given today. If a question is not clear, please ask the pharmacist for help.** | **Yes** | **No** | **I don't know** |
|---|---|---|---|
| Are you sick today? | | | |
| Do you have allergies to medications, food (i.e. eggs), latex or any vaccine component (i.e. polyethylene glycol (PEG), sorbate, neomycin, formaldehyde, gentamicin, thimerosal, bovine protein, phenol, polymyxin, gelatin, baker's yeast or yeast)? | | | |
| Have you ever had a serious reaction after receiving a vaccination? | | | |
| Have you received any vaccinations in the past 4 weeks? | | | |
| Do you have a neurological disorder such as seizures or other disorders that affect the brain or have had a disorder that resulted from a vaccine (i.e. Guillain-Barre Syndrome)? | | | |
| Do you have cancer, leukemia, AIDS, or any other immune system problem? | | | |
| Do you take cortisone, prednisone, other steroids, antivirals, or anticancer drugs, or have you had radiation treatments in the past 6 months? | | | |
| Have you received a transfusion of blood or blood products, including antibodies in the past year? | | | |
| Do you have a history of bleeding problems? | | | |
| **For patients over 65 OR have a chronic condition such as asthma or COPD OR smoke:** Have you received the Pneumococcal or "Pneumonia" vaccine? | | | |
| **For women:** Are you pregnant or could you become pregnant in the next 3 months? | | | |
| **Have you previously had the following vaccines?** | **Yes** | **No** | **I don't know** |
| • Pneumococcal Vaccine (you may need two different pneumococcal vaccines) | | | |
| • Shingles Vaccine (2017 formulation is recommended even if you received prior shingles shot) | | | |
| • Whooping Cough Tdap Vaccine | | | |

I authorize the release of any medical or other information with respect to this vaccine to my healthcare providers, Medicare, Medicaid or other third party payer as needed and request payment of authorized benefits to be made on my behalf to Blacksburg Pharmacy.

- I acknowledge that if my insurance does not cover the cost of administering the vaccine at the pharmacy, then payment must be made at the time of the administration of the vaccine.
- I acknowledge that my vaccination record may be shared with federal or state agencies for registry reporting.
- **I acknowledge that the pharmacist recommends that vaccinated patients should remain in the waiting area, after the administration of the immunization, for 20 minutes or until verbally released.**

*** * * CONTINUE ON NEXT PAGE * * ***

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(540) 552-3000.

- I have read, or have had read to me the Vaccination Information Sheet (VIS) regarding the vaccine(s). I have had the opportunity to ask questions that were answered to my satisfaction and understand the benefits and risks of the vaccines(s). I consent to, or give consent for, the administration of the vaccine(s). I fully release and discharge Blacksburg Pharmacy, its affiliates, their officers, directors, and employees from any liability for illness, injury, or damage which may result there from.
- **I authorize Blacksburg Pharmacy to send copies of my vaccine documents to my primary care provider. YES NO**
  I understand failure to select one of these boxes may result in the vaccine documents being sent to my primary care provider, if known, as state laws and regulations require.
- *(OPTIONAL) I request and authorize Blacksburg Pharmacy to notify the following contact(s) of this vaccination record (e.g. school, employer, travel agency, etc.):* ______________________________

****IF INSURANCE DOES NOT COVER ANY VACCINATION, PLEASE SEE BELOW PRICING****

- **Hepatitis B: $85**
- **Polio: $65**
- **Meningitis: $190**
- **MMR: $95**
- **Tetanus: $65**

**BY SIGNING BELOW, I AGREE TO THE ABOVE STATEMENTS AND POTENTIAL OUT OF POCKET COSTS.**

**x** ______________________________________________

**Patient Signature** (If under the age of 18: Parent/Legal Guardian signature):

****PLEASE RETURN THIS FORM TO OUR STAFF AND PROVIDE YOUR LATEST INSURANCE INFORMATION IF NOT ALREADY ON FILE. THANK YOU!****

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THIS SECTION FOR PHARMACY USE ONLY

| | | | |
|---|---|---|---|
| | □ Hepatitis B | VIS Date: 08/06/21 | |
| | □ IPV (Polio) | VIS Date: 08/06/21 | |
| | □ Meningitis ACWY | VIS Date: 07/06/21 | |
| | □ MMR | VIS Date: 08/06/21 | |
| | □ Tdap (Tetanus) | VIS Date: 08/06/21 | |

Lot #: ______________________
Exp Date: ___________________

Site: LA or RA or OTHER:_____________

Lot #: ______________________
Exp Date: ___________________

Site: LA or RA or OTHER:_____________

Signature of pharmacist who administered vaccine(s) and provided VIS to patient: ______________________________

License #: ______________________________ Date: ______________________

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