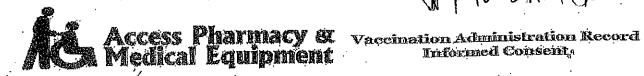
#FW Shotst



First Name:	· , ·	M	I: Last Name	•	DOB:	·	Gender:		
				Last Name: DOB:		State:			
vadiesi.							ne #:		
The following q				o be vaccinated toda	у.	YEŞ	, ŅO	UNSURE	
1. Do you have fever, diarrhea or have you vomited today?									
2. Do you have allergies to medications, foods, or any vaccine?									
3. Have y									
4. Have you ever had a seizure disorder, brain disorder, Guillain-Barre Syndrome? (a condition that causes paralysis) or any other nervous system problems?									
5. Do you have immune system problems, cancer, leukemia, lymphoma, or HIV/AIDS?									
6. Are you currently on home infusions, weeky injections, and/or taking medications such as Remicate®, Humira®, or Kineret®? -Please refer to your Pharmacist if you are unsure of this.									
7. Do you take cortisone, prednisone, other steroids, anticancer drug or have had x-ray treatments?						7			
8. Have you received a transfusion of blood or any blood products, or been given a medicine called immune (gamma) globulin in the past year?									
9. Have you received any vaccinations in the past 4 weeks?							:		
10. WOMEN: Are you pregnant or considering becoming pregnant in the next month?						• • • • • • • • • • • • • • • • • • • •			
11. AGES 65 YEARS OF AGE OR OLDER: Have you ever had a pneumococcal or "Pneumonia" vaccination?						,			
vaccine(s). I und Information Stat were answered to after administrat hold harmless Ad and all liabilities	erstand the risk ements on the volume satisfaction ion for observancess Drugs, LL or claims whet thorize Access	s and benefits a vaccine(s) I have n. Ruther, I ack tion by the admi c, its staff, agen her known or ur Drugs, LLC to re atte care or payn	ssociated with the abo elected to receive. I al nowledge that I have I inistering pharmacist. ts, successors, division aknown arising out of,	I hereby give my conse- bible to predict all possit- ve vaccine(s) and have: so acknowledge that I i been advised to remain On behalf of myself, m is, affiliates, subsidiarie in connection with, or i other information to he ayment of authorized h	nave had a chance to as near the vaccination loo y heirs, and personal re s, offices, directors, con in any way related to the	k questions cation for a presentativ tractors, a e administr Medicare.	s and that supproximate peroximate yes, I hereby and employe ation of the Medicaid, or	teh questions ly 15 minutes release and es from any vaccine(s) r other third	
- ,				-	Detai				
Signa (Person	ture:	cine(s) or Par	ent or Guardian, if r	ecipient is a minor)	Date:	· · · · · · · · · · · · · · · · · · ·		_	
Pharmacy l		•			,				
		print):			RPh/Phar	mD			
Immunizer Name (print):						mD			
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Inter		_			VIS Given to Recipie	nt.			
Vaccino attinino dello di socio						•		4- DAIL Cont	
Vaccine	Lot#	Exp. Date	Maufacturer	Dosage	Site of Injection	VIS Dat	e Da	ate PNL Sent	
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