Dedrick's
PHARMACY + GIFT SHOP

PATIENT INFORMATION

LAST NAME:_____ PERMANENT ADDRESS:_____

FIRST NAME:_____ CITY:_____

MIDDLE INITIAL:_____ STATE/ZIP:_____

DATE OF BIRTH:_____ LOCAL ADDRESS:_____

AGE:_____ CITY, STATE/ZIP:_____

PHONE NUMBER:_____ EMAIL:_____

MEDICATION ALLERGIES: PLEASE LIST REACTION (RASH, NAUSEA, ,ETC) FOR ANY ALLERGY

_____

_____

NOTE: PLEASE BRING YOUR PRESCRIPTION INSURANCE CARD. MANY PRESCRIPTION INSURANCE CARDS WILL BE DIFFERENT THAN YOUR MEDICAL INSURANCE CARD.

Primary Care Physician(PCP):

Name of PCP:_____

Contact Information (phone number, address):_____

_____

_____ _____

PATIENT (REPRESENTATIVE) SIGNATURE DATE

For Pharmacy Use Only:			
Notice of Privacy Practices: I hereby acknowledge that I have received Dedrick's Pharmacy's Notice of Privacy Practices.			
I hereby acknowledge I received the prescription number listed below			
RX NUMBER	PATIENT NAME	PATIENT SIGNATURE	DATE

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Screening Checklist For Contraindications to Inactivated Injectable Influenza Vaccination

For patients to be vaccinated: The following questions will help us determine if there is any reason we should not give you inactivated injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't Know
1. Is the person to be vaccinated sick today?			
2. Does the Person to be vaccinated have an allergy to eggs or to a component of the vaccine?			
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?			
4. Has the Person to be vaccinated ever had Guillain-Barre Syndrome?			
5. For women: Are you pregnant or is there a chance you could become pregnant during the next month?			

Immunization Consent:
I have read, or had explained to me, the Vaccine Information Statement about my influenza vaccination. I have had a chance to ask questions, which were answered to my satisfaction, and I understand the benefits and risk of the vaccination as described. I request that the influenza vaccination be given to me (or the person named above for whom I am authorized to make this request). I authorize the release of any medical or other information necessary to process a medicare or other insurance claim or for other public health purpose including the NYS Immunization Registry NYIIS.

X_____Signature of patient or person authorized to make the request

Primary Care Physician(PCP):

Name of PCP:_____

Contact Information (phone number, address):_____

_____

For Pharmacy Use- Pharmacist Name:							
Vaccine	Lot #	Exp Date	MFG	VIS Date	Date Given	Route/Site	Vaccinator
Influenza IIV4						L / R IM	