Store #:_____
(store use)

Vaccine Administration Record

Information about the person to receive the vaccine:
Please answer all questions. If the personal information asked for is NOT provided, the immunization service may be denied. Except as required by law, this information is confidential and will not be shared with anyone without your specific authorization.

Last Name_____ First Name_____ Gender_____

Birth Date___/___/_____ Age_____ Phone # (Primary) ___–___–_____ Facility/Company (If applicable)_____

Address_____ City_____ State_____ Zip_____

Primary Care Provider Name, Location_____ Provider's Phone #___–___–_____

****Patient: To ensure proper billing, please include a copy of your most current insurance card(s) you would like us to bill.****

Rx Plan Name:_____ BIN _____PCN _____ ID# (include ALL letters and #s)_____Group#_____

Medical Plan Name:_____Group# _____ID# (include ALL letters and #s)_____Other#_____

Vaccines I am interested in receiving today: _____ TWRx ID: _____ (store use – if applicable)

All Vaccines *(please answer questions 1 – 8 for all vaccines)*

1. Is the person to be vaccinated sick today?	☐ Yes	☐ No	☐ Don't know
2. Has the person to be vaccinated previously had the vaccine(s) they are about to receive today?	☐ Yes	☐ No	☐ Don't know
3. Does the person to be vaccinated have allergies to medicine, foods (ex. Eggs), a vaccine component, or latex?	☐ Yes	☐ No	☐ Don't know
4. Has the person to be vaccinated ever had a severe reaction after receiving ANY vaccine in the past?	☐ Yes	☐ No	☐ Don't know
5. Does the person to be vaccinated have a long-term health problem with heart disease, lung disease, asthma (including wheezing), kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder? Or if this is a child, have they been on long-term aspirin therapy?	☐ Yes	☐ No	☐ Don't know
6. Has the person had a seizure, or brain or other nervous system problem such as Guillain-Barré syndrome?	☐ Yes	☐ No	☐ Don't know
7. *For women:* Is the person to be vaccinated currently pregnant, planning to become pregnant in the next 3 months, or breastfeeding? (if applicable)	☐ Yes	☐ No	☐ Don't know
8. Are you interested in other Thrifty White Pharmacy vaccinations and services?	☐ Yes	☐ No	☐ Don't know

Live vaccines (flu nasal spray, shingles, chicken pox, MMR, oral typhoid) *Answer questions 9-12 if you are receiving any immunizations listed.*

9. Does the person to be vaccinated have cancer, HIV or any other condition that weakens the immune system?	☐ Yes	☐ No	☐ Don't know
10. Has the person to be vaccinated taken medications in the past 3 months that would weaken the immune system such as cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments?	☐ Yes	☐ No	☐ Don't know
11. Has the person to be vaccinated received any vaccinations in the past 4 weeks?	☐ Yes	☐ No	☐ Don't know
12. Has the person to be vaccinated received any blood products, immune globulins or antivirals in the past year?	☐ Yes	☐ No	☐ Don't know

Consent for Vaccination: I certify that I am: (i) the patient and at least 18 years of age; (ii) the parent or legal guardian of the minor patient who is at least the minimum age required by State law to receive the vaccine; or (iii) the legal guardian of the patient. I was given a copy of the most current Vaccine Information Statement (VIS) regarding the vaccine that will be administered today. I have had a chance to ask questions, which were answered to my satisfaction. I understand the benefits and risks of the vaccination as described. I hereby give my consent and request that the vaccine be administered to me or the person named above, a minor or an individual for whom I represent and for whom I am authorized to sign this consent. I have been advised to remain in the vaccination area for approximately 15 minutes for observation after the vaccine has been administered. In those states that require such recording, I hereby consent to the pharmacy recording this vaccination in the state vaccination registry. I, for myself and the recipient of the vaccination, if the recipient is a minor or an individual for who I am the legal guardian, my heirs and personal representatives, hereby release and hold harmless Thrifty Drug Stores, Inc. and its employees, agents and representatives from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed below.

Authorization to bill: I hereby authorize Thrifty White Pharmacy to bill Medicare or my health insurance for immunization services. I understand that the pharmacy will be reimbursed directly from Medicare or my insurance plan. I understand that the patient, the parent if the patient is a minor, or the patient's legal guardian is responsible for payment of co-pays, co-insurance and any claims denied by the insurance.

_____ _____ _____

Signature of patient, parent or legal guardian | Printed Name of the patient, parent or legal guardian | Today's Date

******To be completed by Vaccine Administrator******

Date of Administration____/____/_____

Vaccine _____ Dose _____

NDC # _____

Manufacturer _____

Lot Number _____ Expiration ___/____/_____

Injection Site: R L Deltoid or _____

Route: IM SQ Intranasal ID

Date VIS provided: __/__/___ VIS version date: __/__/___

_____|_____

Administered by, title (print) **Signature**

☐ **Billed in store** ☐ **A/R to bill**

☐ Personal Insurance ☐ Group Charge Acct
Acct#:_____
Name:_____
Price:_____

☐ Cash ☐ VFC

Affix Rx label here

or enter Rx #_____