

TW 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 # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Facility/Company \_\_\_\_\_  
(Primary) (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 whom 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#: \_\_\_\_\_  
 Cash  VFC Name: \_\_\_\_\_  
 Price: \_\_\_\_\_

