

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: _____

