TW Store #:_____
(Store use)

# Vaccine Administration Record

**Information about the person receiving 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 outside of Thrifty White 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. Are you sick today? | ☐ Yes | ☐ No | ☐ Don't know |
| 2. Have you ever gotten the vaccine(s) they are about to receive today? (In past years) | ☐ Yes | ☐ No | ☐ Don't know |
| 3. Do have allergies to medicine, foods (ex. Eggs), a vaccine component, or latex? | ☐ Yes | ☐ No | ☐ Don't know |
| 4. Have you ever had a severe reaction after receiving ANY vaccine in the past? | ☐ Yes | ☐ No | ☐ Don't know |
| 5. Do you have a long-term health problem such as 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. Have you had a seizure, or brain or other nervous system problem such as Guillain-Barré syndrome? | ☐ Yes | ☐ No | ☐ Don't know |
| 7. *For women:* Are you currently pregnant or planning to become pregnant in the next 3 months? | ☐ 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, ZVL, chicken pox, MMR, oral typhoid) *Answer questions 9-12 if you are receiving any immunizations listed.*

| | | | |
|---|---|---|---|
| 9. Do you have cancer, HIV or any other condition that weakens the immune system? | ☐ Yes | ☐ No | ☐ Don't know |
| 10. Have you 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. Have you received any vaccinations in the past 4 weeks? | ☐ Yes | ☐ No | ☐ Don't know |
| 12. Have you received any blood products, immune globulins or antivirals in the past year? | ☐ Yes | ☐ No | ☐ Don't know |
| 13. *For women:* Are you currently breastfeeding? | ☐ 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, my health insurance, or my employer for immunization services. I understand that the pharmacy will be reimbursed directly from Medicare, my insurance plan, or my employer. **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 my health insurance or other third party payer.**

_____ _____ _____

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

Request for Chaperone? Y or N

_____ _____

*Name of Chaperone* | *Relationship of Chaperone to Patient*

******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**

Patient's current pharmacy (if not TW): _____ (Optional)

☐ Personal Insurance ☐ Group Charge Acct

☐ Cash ☐ VFC

Acct#:_____

Name:_____

Price:_____

***Affix Rx label here***

***or enter Rx #_____***