
 (205) 921-3193

 fredsrpharmacy.com

 (205) 921-2576

 797 Military St, Hamilton, Alabama 35570

IMMUNIZATION FORM

PATIENT DETAILS

Patient's Name (Last Name, First, Middle): _____ Date of Birth: _____

Delivery Address (City, State, Zip Code): _____

Insurance Name: _____ ID Number: _____

Please answer Questions 1-8 for a **Influenza Vaccine** and Questions 1-6, 9, and 10 for **pneumococcal Vaccine**

- | | | |
|---|------------------------------|-----------------------------|
| 1. Are you under the age of 18? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Do you have a known or suspected pregnancy? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Are you currently ill or have a fever? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Are you currently on antibiotics? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Do you have or ever had Guillain-Barre' Syndrome? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Do you have an allergy to eggs? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Have you ever had the influenza vaccine before? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Have you ever had an allergic reaction to influenza vaccine? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. Have you ever had a pneumococcal vaccine? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| a. If Yes, when? _____ | | |
| 10. Have you ever had an allergic reaction to the pneumococcal vaccine? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

I have read or have had explained to me, information about Influenza/pneumococcal Vaccines. I have had a chance to ask questions, which were answered to my satisfaction. I understand the benefits and risks of receiving the influenza/Pneumococcal vaccine and request that the vaccine be given to me, or to the person named for who I am authorized to make this request.

I acknowledge receiving the pharmacy's Notice of HIPPA privacy practices.

I wish to have Fred's Pharmacy bill my insurance for the vaccination given. I authorize the release of any medical or other information necessary to process this claim. I request that payment of my insurance benefits be paid directly to Fred's Pharmacy. If for any reason my insurance refuses payment to Fred's Pharmacy I realize that I will be liable for the full amount due to Fred's Pharmacy and any expense Fred's Pharmacy may incur in collecting this debt.

Signature of person to receive vaccine or authorized to make the request

Date

----- FOR PHARMACY USE ONLY -----

INFLUENZA / H1N1 VACCINATION

PNEUMOCOCCAL VACCINATION

MANUFACTURER AND VACCINE NAME: _____ LOT NUMBER: _____

NDC#: _____ EXPIRATION DATE: _____

SITE OF INJECTION: LEFT DELTOID

RIGHT DELTOID