# IMMUNIZATION REQUEST

**PATIENT INFORMATION:**

Patient Name:_____ Allergies:_____

D.O.B.:_____ Sex: M or F

Address: _____ City:_____ State:_____ Zip:_____

Phone: _____

**BILLING INFORMATION** PLEASE CHECK HERE ☐ IF PAYING CASH

**USING YOUR MEDICARE (RED, WHITE, & BLUE) CARD…**

**FULL NAME AS IT APPEARS ON MEDICARE CARD:** _____

**MEDICARE ID # (INCLUDING ANY LETTERS):** _____

**USING YOUR PRESCRIPTION INSURANCE CARD…**

IF WE FILL YOUR PRESCRIPTIONS, THEN WE'VE GOT IT ON FILE

IF WE ***DO NOT*** FILL YOUR PRESCRIPTION, PLEASE PRESENT YOUR CARD WITH THIS FORM WHEN COMPLETED

**Circle One:** Cardholder Spouse Child

**ANSWER QUESTIONS AND SIGN WAVER:**

| | | |
|---|---|---|
| 1. Are you sick today? Fever? Diarrhea? | Y | N |
| 2. Do you have allergies to medications (neomycin,etc.), food (eggs), or any vaccine? | Y | N |
| 3. Have you ever had a serious reaction after receiving a vaccination? | Y | N |
| 4. Do you have cancer, leukemia, AIDS, or any other immune system problem? | Y | N |
| 5. Do you take cortisone, prednisone, methotrexate, other steroids, or anticancer drugs, or have you had x-ray treatments? | Y | N |
| 6. During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin? | Y | N |
| 7. For women: Are you pregnant or is there a chance you could become pregnant during the next month? | Y | N |
| 8. Have you received any vaccinations in the past 4 weeks? | Y | N |

**I authorize Kare Drug to prescribe, administer, and bill for immunizations requested and have provided accurate and current insurance information for insured dependents and/or agree to be financially liable for all vaccinations and administration fees for uninsured patients and/or their dependants. I acknowledge that the pre-vaccination questionnaire has been answered truthfully and honestly to the best of my ability. I have read and understand the Vaccination Information Statement (VIS) provided for me. I authorize the release of these immunization records to the New Mexico Department of Health.**

**Patient Signature:** _____ **Date:** _____

**IMMUNIZATION(S) PROVIDED:**

| Vaccine | Date | Site | By | Vaccine | Lot # | Exp. Dt. | VIS date |
|---|---|---|---|---|---|---|---|
| Influenza (IM) | | | | Flucelvax Quad | | | 08/15/2019 |
| Prevnar 13 (IM) | | | | Conjugate | | | 10/30/2019 |
| Pneumovax 23 (IM) | | | | Polysaccharide | | | 10/30/2019 |
| Tet/Diphth/Pertussis (IM) | | | | Adacel | | | 04/01/2020 |
| Shingles (IM) 1st dose | | | | Shingrix | | | 10/30/2019 |
| 2nd dose (month 2-6) | | | | Shingrix | | | 10/30/2019 |

Prescribed By: _____