



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 WAIVER:

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 dependents. 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	195218	April-18	08/07/2015
Pevnar 13 (IM)				Conjugate			11/05/2015
Pneumovax 23 (IM)				Polysaccharide			04/24/2015
Tet/Diphth/Pertussis (IM)				Adacel			02/24/2015
Shingles (SQ)				Zostavax			10/06/2009

Prescribed By: _____