MILLS PHARMACIES
VACCINE ADMINISTRATION RECORD

Name _____ Male __ Female __ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Phone _____ Medicare # (including letters) _____

Allergies _____ Primary Care Physician and Phone Number _____

Emergency Contact Name:_____ Phone _____

Ethnicity (optional): Caucasian African-American Hispanic Asian American Indian Other:_____

For Patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any questions, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it further.

Screening Questions

1. Are you sick today?	YES	NO
2. Do you have allergies to medications, food, eggs, yeast, a vaccine component, or latex?	YES	NO
3. Have you ever had a serious reaction after receiving a vaccination?	YES	NO
4. Do you have a long-term health problem such as heart disease, lung disease, liver disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia or other blood disorder?	YES	NO
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem? Have you been diagnosed with rheumatoid arthritis, ankylosing spondylitis, Crohn's disease, herpes, or cold sores?	YES	NO
6. In the past 3 months, have you taken medications that weaken your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?	YES	NO
7. Have you had a seizure or a brain or other nervous system problem or Guillain Barre?	YES	NO
8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug (including acyclovir, famciclovir, valacyclovir)?	YES	NO
9. Have you received any vaccinations in the past 4 weeks?	YES	NO
10. Do you have a history of fainting, particularly with vaccines?	YES	NO
11. **For women**: Are you pregnant or is there a chance you could become pregnant during the next month?	YES	NO
12. **For Tdap and adult Td**: Do you have a cut, injury, puncture or open wound that prompted you to get a tetanus shot?	YES	NO
13. **For Zoster**: Have you had a past reaction to gelatin or triple antibiotic ointment?	YES	NO

MEDICARE RECIPIENTS PLEASE COMPLETE THE SECTION BELOW:

Please check one:

☐ *I hereby authorize Mills Pharmacy to bill Medicare Part B/D on my behalf. I request that payment of authorized Medicare benefits be made to Mills Pharmacy for the above vaccine and its administration as furnished to me by Mills Pharmacy. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits payable for related services.*

☐ *I hereby attest that as of the date indicated above, I am not enrolled in Medicare Part B/Part D.*

PRIVATE INSURANCE HOLDERS PLEASE COMPLETE THE SECTION BELOW:

Please check one:

☐ *I hereby authorize Mills Pharmacy to bill _____ (insurance) on my behalf. I request that payment of authorized benefits be made to Mills Pharmacy for the above vaccine and its administration as furnished to me by Mills Pharmacy. I authorize any holder of medical information about me to release to _____ _____ (insurance) and its agents any information needed to determine these benefits payable for related services.*

Subscriber ID #:_____ **Group #:**_____ **BIN#:**_____

I have read, or have had read to me, the written information regarding the vaccine(s) marked above. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) being administered and have received a copy of a current Vaccine Information Sheet for each vaccine I am receiving today. I, on behalf of myself, my heirs, executors, personal representatives, agents, successors, and assigns hereby agree to release, indemnify, and hold harmless Mills Pharmacy, its subsidiaries, divisions, affiliates, agents, officers, directors, contractors, and employees from any and all claims arising out of, in connection with, or in any way related to the administration of the vaccine(s) marked above. I further authorize the administrator to notify my primary care physician and/or public health department of my receiving this vaccine if determined appropriate. I certify that I am at least 18 years old and hereby give my consent to the pharmacists of this store to administer the vaccine(s) marked above. If under 18 years old signature by parent or guardian required. **I AGREE TO WAIT NEAR THE VACCINATION LOCATION FOR APPROXIMATELY 15 MINUTES FOR OBSERVATION BY A PHARMACIST.**

Signature: _____ **Date:** _____

Printed Name: _____

Vaccine	Date	Manufacturer	Lot #	Exp	Site	VIS Given	VIS Date	MD Notified	Initials