CRAIG'S DRUG STORE
MEDICAL EQUIPMENT & SUPPLY
Caring Since 1867

First & Last Name: _____ **Date of Birth:** _____

Gender: M / F **Phone Number:** _____ **Age:** _____

Address: _____

City: _____ **State:** _____ **ZIP Code:** _____

Primary Physician/Prescriber Information:
Name: _____ **Phone:** _____
Address: _____ **City:** _____ **State:** _____

For Medicare B Beneficiaries:
Medicare Number: _____ **Effective Date:** _____

What vaccination would you like to receive today? _____

Questions:	Yes	No	Unsure
Are you sick today?			
Do you have any allergies to medications, food or vaccine components?			
Are you allergic to eggs or chicken egg products specifically?			
Do you have an allergy to gelatin and neomycin? (Herpes Zoster only)			
Do you have an allergy to phenol? (Pneumococcal only)			
Have you ever had a serious reaction after receiving a vaccination?			
Do you have cancer, leukemia, AIDS, or any other immune system problem?			
Do you take cortisone, prednisone, other steroids, anticancer drugs, or do you receive x-ray treatments?			
During the past year, have you received a transfusion on blood or blood products, or been given a medicine called immune globulin?			
Have you received any vaccinations in the past 4 weeks?			
For women: Are you pregnant or is there a chance you could become pregnant within the next month?			

Consent for Administration of Vaccine(s): I have read, or have had read to me, the information regarding the vaccine and have been given a copy of the vaccination information. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine. I consent to, or give consent for, the administration of the vaccine(s).
Signature: _____ **Print Name:** _____

FOR PHARMACY STAFF ONLY

Vaccine Name:	**VIS Date:**
Manufacturer:	**Admin. Date:**
Lot Number:	**Dose:**
Expiration Date:	**Site & Route:**

_____ Name & Credentials of Vaccinator

_____ Signature of Vaccinator

Faxed on: _____
Added to Immunet on:_____