INFLUENZA VACCINATION ADMINISTRATION RECORD

Hudson Drug and Hallmark Shop
108 N. Market St., Paxton, IL
(217) 379-4858

Note: You must wear a mask covering both your nose and mouth

Last Name (Please Print Clearly) | First Name | Middle Name

Mailing Address | City, State, & ZIP | Temperature

Phone Number | Date of Birth (MM/DD/YY) | Gender

Insurance ID # | BIN # | PCN # | RX Group

Medicare #

Read The Following Questions And Check The Box That Applies

	YES	NO
1. Are you sick with a fever? Or feeling severely ill today? Displaying any COVID-19 symptoms?	☐	☐
2. Have you had an adverse reaction (i.e. requiring medical attention) to any vaccine in the past?	☐	☐
3. Are you allergic to chicken eggs, latex or thimerosal (a preservative)?	☐	☐
4. Do you take Cortisone, Prednisone, other steroid, anticancer medications, or have had X-ray treatments?	☐	☐
5. Do you have a history of developing Guillain-Barre Syndrome?	☐	☐
6. For women: Are you pregnant or is there a chance that you could be pregnant?	☐	☐
7. Are you taking any medication that may cause you to bleed, such as aspirin or coumadin?	☐	☐
8. Have you been exposed to a person testing positive for COVID-19 in the last 14 days?	☐	☐

I have received and read/had explained to me the vaccine Information statement(s) (vis) on the vaccine(s) given. I had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks. I request that the vaccine(s) be given to me or the person named above for whom I am authorized to make this request. I agree that the administering pharmacy shall have no responsibility or liability if I contract influenza, other respiratory diseases, or suffer any other adverse reaction following administration of my shots. In addition, for those to whom it applies, I ask that payment of authorized medicare/HMO benefits be made on my behalf to the administering pharmacy for the immunization administered to me. I am authorizing any holder of medical or other information about myself to be released to CMS, MCIR and its agents, including my information needed to determine any and all benefits for related services. I acknowledge a receipt for privacy notice.

Signature | Date

I wish to have my immunization record sent to my primary physician. ☐ Yes ☐ No

Name of Primary Physician

Injection Site: ☐ Right Arm ☐ Left Arm

Administrative Use Only

Type of Vaccine | Lot #

Manufacturer # | Date on VIS

Administrator Name

Administrator Signature | Date

Rev: 8/2020