Vaccine Administration Record

Last Name: _____ First Name: _____ MI: _____ Birthdate:_____

Gender: __M __F Phone Number: _____ Email: _____

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

Allergies: _____

Primary Care Provider: _____ Phone: _____ Fax:_____

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

Screening Questions

Have you ever had a severe reaction to previous vaccines or any vaccine component or have a history of fainting particularly with vaccines?	Yes	No
Do you have any allergies to medications, food, latex , yeast, eggs, gelatin, neomycin, or thimerosal?	Yes	No
Has any health care provider cautioned or warned you about receiving vaccines outside of a medical setting?	Yes	No
Are you sick today or do you currently have a fever, diarrhea, vomiting, or infection?	Yes	No
Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	Yes	No
Do you have any CHRONIC health conditions? If yes, please list: _____	Yes	No
During the past year have you received a blood transfusion or been given gamma globulin or an antiviral drug?	Yes	No
In the past 3 months have you taken medications that weaken your immune system	Yes	No
(Medications include: cortisone, prednisone, anticancer drugs,or radiation treatments)		
Have you received any vaccinations or TB skin test within the last 4 weeks?	Yes	No
Have you had a seizure or other nervous system problem or a history of of Guillian-Barre?	Yes	No
For Women: Are you are pregnant or a chance you may become pregnant within the next month?	Yes	No
For Tdap : Do you have a cut, injury or puncture wound that prompted you to get a shot?	Yes	No
For Zoster: Have you had a past reaction to gelatin or triple antibiotic ointment?	Yes	No

Billing Information and Consent

I hereby authorize Triad Care to bill my insurance or Medicare information listed below on my behalf. I request that payment of authorized benefits be made to Triad Care for the vaccine listed below and its administration as furnished to me by Triad Care. I authorize any holder of medical information about me to release to the insurance listed below and its agents any information needed to determine these benefits payable for related services.

Insurance:_____ Subscriber ID:_____ Group:_____

Cardholder's Name: _____ DOB:_____ (Required if not the vaccine recipient)

I hereby certify that the foregoing history is true and complete to the best of my knowledge and I have received and read the "Vaccine Information Statement" from the CDC, have had an opportunity to ask questions that were answered to my satisfaction, and do wish to receive the flu vaccination fully understanding the risks and the benefits. I hereby consent to the administration of the flu vaccine. I fully release and discharge the standing order physician and Triad Care, Inc., its affiliations and their officers, and the employees from any illness, injury, loss, or damages that may result there from. I acknowledge that I have received a copy of Triad Care's privacy policies according to HIPPA. I assign payment of authorized insurance benefits due to me to be paid to Triad Care, Inc. and will pay any co pay or deductible that result. I consent the release of medical information when necessary for billing, reimbursement, and medical protocol. I certify I am at least 18 years old and hereby give my consent to Triad Care, Inc.to administer the vaccine stated above. If under 18 years old signature by parent or guardian required. **I agree to wait near the vaccination area for approximately 15 minutes to receive treatment in case of adverse reaction**.

I understand that my health insurance company may deny payment for the services of this immunization. If my health insurance company denies payment, I agree to be personally responsible for full amount due. I understand that if my health insurance company makes a partial payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies.

Signature of Patient or Parent/Guardian: _____ Date: _____

For Triad Care Use Only

Vaccine to be administered: ____ Influenza ____ Pneumococcal ____ Tdap ____ Hepatitis B ____ Zoster

Product:_____ Manufacturer: _____ Lot#_____ Expiration Date: _____ Dose: _____

Site of Injection: __LD or __RD Signature and Title of Vaccine Administrator:_____ VIS Date _____