Vickery Vaccine SERVICES

3959 Welsh Road • Suite 107
Willow Grove, PA 19090

267.477.1010
Fax 267.953.2778

Universal Vaccination Form

Patient Data

First Name	M.I.	Last Name	DOB	M/F

Address	City	State	Zip

Phone	Email	SS# or Driver's License #

Medical Health Plan

Name of Medical Plan	
ID #	Group #

Prescription Health Plan

Name of Prescription Plan		Group #
ID #	Bin #	PCN #

Patient Screening Questionnaire for Vaccination

If for any reason a question is not clear, please ask.

	Yes	No	Not Sure
1. Are you sick today?			
2. Do you have allergies to food, medication, or any vaccine?			
3. Are you allergic to eggs?			
4. Are you allergic to latex?			
5. Do you have a history of Guillaim-Barre syndrome?			
6. Have you ever had a serious reaction after receiving a vaccination?			
7. Do you have cancer, leukemia, AIDS, or any other immune system problem?			
8. Do you take cortisone, prednisone, other steroids, or anticancer drugs or any x-ray treatments?			
9. Do you have a seizure or brain problem?			
10. During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin?			
11. Are you pregnant or is there a chance you could become pregnant during the next 3 months?			
12. Have you received any vaccination in the past 4 weeks? *(Please list)*			

Primary Physician

Physician/Group Practice	Address		
City	State	Zip	Fax #

Agreement and Authorization for Release of Medical Information

The undersigned does hereby authorize Pharmacy to release information to the primary physician identified above regarding vaccinations received today as well as verifies that the above information in correct and assumes full responsibility for payment should my insurance provider decline to pay for any reason.

Patient/Guardian Signature	Patient/Guardian Name (Print)	Date
X		

Pharmacy Notations (Pharmacy Use Only)

Vaccine	Mfg.	Lot#	Exp.	Inj. Site	By
Vaccine	Mfg.	Lot#	Exp.	Inj. Site	By
Vaccine	Mfg.	Lot#	Exp.	Inj. Site	By
Vaccine	Mfg.	Lot#	Exp.	Inj. Site	By

VIS Date	Payment Method			
	CC $ _____	Check $ _____	Cash $ _____	Bill Patient $ _____