O	Cash
O	Medicare
O	Insurance

VACCINE ADMINISTRATION RECORD

TRS member ID ____________________

Medicare #: __________________ ***Please include the letter following your Medicare Number**

Injection Requested: O Flu O Pneumonia O Meningitis O Shingles O Tetanus/whooping cough

PERSONAL INFORMATION (Please Print):

Name: ____ Date of Birth: __________________

Gender M / F Phone: ____________________ Allergies: _________________________

Address: ____________________________ City: __________________ ST: ____ Zip: __________

Primary Care Physician: __________________________ City: _______________________

Screening questionnaire for Immunizations

Authorization to Administer

		Yes	No	Don't know	Not Applicable
1.	Are you sick today?	O	O	O	O
2.	Do you have any allergies to medications, eggs, any vaccines, vaccine components, brewer's yeast, streptomycin, neomycin, gelatin etc.?	O	O	O	O
3.	Have you ever had a serious reaction to a vaccine?	O	O	O	O
4.	Do you, any person who lives with you, or any person you take care of, have cancer, leukemia, AIDS, or any other immune system problems?	O	O	O	O
5.	Do you, any person who lives with you, or any person you take care of, take cortisone, prednisone, other steroids, anti-cancer drugs, or radiation treatment?	O	O	O	O
6.	During the past year have you received a blood or plasma transfusion, or been given a medicine called immune globulin?	O	O	O	O
7.	For women: Is it possible that you are pregnant or may become pregnant in the next 3 months?	O	O	O	O
8.	Have you ever had a confirmed case of chicken pox?	O	O	O	O
9.	Have you ever had a case of shingles?	O	O	O	O

Signature of person to receive vaccine or person authorized to make the request (parent or guardian):

X ____ **Date:** ________________________

Office Use Only:	Site	Dose	Lot #	Exp Date	Manf	Signature
O Flu	LD / RD IM Intranasal	0.5 cc				
O Pneumonia	LD / RD IM	0.5 cc				
O Menactra	LD / RD IM	0.5 cc				
O Zostavax	LD/RD SQ	0.65 cc				
O Tdcap	LD/RD IM	0.5 cc				