ENGLISH PLAZA PHARMACY 221-3090 JASPER

FMS PHARMACY 424-3194 BESSEMER

MONTEVALLO DRUG 665-1261 MONTEVALLO

ROSS BRIDGE PHARMACY EST. 2018

FAMILY MEDICAL SERVICES, INC.

Vaccination Form

Patient Name: _____ Date of Birth:_____
(First) (Middle (Last)

Email Address: _____Known Allergies: _____

Home Street Address: _____City _____

State:_____Zip:_____ Phone Number _____

Primary ***Drug Insurance*** #'s (BIN, ID, GRP, PCN): _____

Primary Doctor (Name) _____City/St _____ _____

Please answer the following questions:

1. Do you feel sick today? YES NO
2. Do you have allergies to latex, eggs or vaccine components? YES NO
3. Do you have cancer, HIV/AIDS, or other immune system disorder including taking medications to weaken your immune system? YES NO
4. Have you had any other vaccinations in the last 4 weeks? YES NO
   If yes, please list:_____
5. Have you ever had a seizure disorder, brain disorder, Guillian-Barré syndrome,or other nervous system problem? YES NO
6. Are you pregnant or nursing? YES NO

By signing below, I acknowledge that I have received a copy of the most current Vaccine Information Statement (VIS) for all vaccines received. I authorize Family Medical Services, Inc. to administer the vaccine and bill my insurance provider if applicable OR charges me the current vaccine rate.

Patient Signature: _____Date:_____

The following section is to be completed by the health care provider only.

Vaccine:	**Exp date:**	**Lot #:**	**Manufacturer:**	**Route/Site:**
Influenza	_____	_____	_____	_____
Pneumococcal	_____	_____	_____	_____
Shingles	_____	_____	_____	_____
Other	_____	_____	_____	_____

Immunizer Signature: _____Title: _____ Date: _____

Provider #: 051558502