



IMMUNIZATION REQUEST

Carlsbad School Employees



PATIENT INFORMATION:

Patient Name: _____ D.O.B.: _____ Sex: M or F
 Address: _____ City: _____ State: _____ Zip: _____
 Phone: _____ Email: _____
 Physician: _____

***MEDICAID DOES NOT COVER VACCINATIONS THROUGH OUR CLINIC.**

BILLING INFORMATION

CASH MEDICARE OTHER

MEDICARE ID #: _____

PRESCRIPTION INSURANCE CARD

Medco: NMPSIA Medco: State of NM



ID # _____

Circle One: Cardholder Spouse Child

* Immunizations are offered as a benefit covered under PAID prescription insurance with no co-payment required. All patients not covered under this insurance will be responsible for vaccination payment.

ANSWER QUESTIONS AND SIGN WAIVER:

- | | |
|---|-------|
| 1. Are you sick today? Fever? Diarrhea? | Y N |
| 2. Do you have allergies to medications (neomycin, etc.), food (eggs), or any vaccine? | Y N |
| 3. Have you ever had a serious reaction after receiving a vaccination? | Y N |
| 4. Do you have cancer, leukemia, AIDS, or any other immune system problem? | Y N |
| 5. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had x-ray treatments? | Y N |
| 6. During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin? | Y N |
| 7. For women: Are you pregnant or is there a chance you could become pregnant during the next month? | Y N |
| 8. Have you received any vaccinations in the past 4 weeks? | Y N |

I authorize Southwest Pharmacy Pharmacists to prescribe, administer and bill for immunizations requested and have provided accurate and current insurance information for insured dependents and/or agree to be financially liable for all vaccinations and administration fees for uninsured patients and/or their dependants. I acknowledge that the pre-vaccination questionnaire has been answered truthfully and honestly to the best of my ability. I have read and understand the Vaccination Information Statement (VIS) provided for me. I authorize the release of these immunization records to my physician and the New Mexico Department of Health.

Patient Signature: _____ Date: _____

SELECT IMMUNIZATIONS YOU NEED BY CHECKING THE BOX TO THE LEFT OF THE NAME:

Vaccine	Date	Site	By	Vaccine	Lot #	Exp. Dt.	VIS date
<input type="checkbox"/> Influenza (IM)				Fluviron			7/26/2011
<input type="checkbox"/> Hepatitis A (IM)				Havrix			3/21/2006
<input type="checkbox"/> Hepatitis B (IM)				Enerix			7/18/2007
<input type="checkbox"/> Hep A/B Combo (IM)				TwinRix			n/a
<input type="checkbox"/> HPV Human Papillomavirus				Gardasil			2/2/2007
<input type="checkbox"/> Meningococcal (IM)				Menactra			8/16/2007
<input type="checkbox"/> Pneumococcal (IM)				Pneumovax			7/29/1997
<input type="checkbox"/> Tet/Diphth/Pertussis (IM)				Adacel			7/12/2006
<input type="checkbox"/> Zostavax (SQ)				Zostavax			10/6/2009

Prescribed By: _____