LAKE MURRAY DRUG CO.

105 Snapdragon Court Suite A
Chapin, SC 29036
803.345.9999

Vaccine Notification and Administration Record

Dear Healthcare Provider:_____ @ fax #_____

We recently administered vaccination services to the patient listed below. We report all vaccines to the state registry, but we also want you to have this information so your patient's medical record is updated.

Patient Name			Date of Birth: MM/DD/YY _____/_____/_____	
Address:			City, State:	
Phone Number:			Email:	
Physician's Name:			Medicare or Insurance Policy Number:	
Mother's Maiden Name (used for State Registry):				
Type of Vaccine: ☐ Influenza ☐ Pneumococcal ☐ Tdap ☐ Other_____				
Date of Vaccination(s):			☐ Male ☐ Female	
Vaccine Name and Dose:	Mfr:	Lot Number:	Expiration:	IM / SQ Left / Right
Second Vaccine Name and Dose:	Mfr:	Lot Number:	Expiration:	IM / SQ Left / Right
RPH Name and License #			RPH Signature:	
VIS Date):			Adverse Reaction (if applicable):	
☐ Scanned ☐ Faxed				

I have read or have had read to me, the information regarding the vaccine(s) marked above and have received the most current vaccine information statement (VIS). I have had the opportunity to ask questions and they were answered to my satisfaction. I understand the benefits and risks of the vaccine(s). I consent to, or give consent for the administration of the vaccine(s) marked and request payment be made to the above-named provider.

For the services provided to me by this provider, I authorize any holder of medical information about me to be released to the centers for Medicare and Medicaid Services, South Carolina Medicaid, Blue Cross and Blue Shield or other carriers or their agent's information needed to determine these benefits or the benefits payable for related services.

_____ Name (Printed)

_____ Signature

This box for Pharmacy Use

Place RX Label Here

This box for Pharmacy Use

Place RX Label Here