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

LAKE MURRAY DRUG CO. Insurance Card:_____ ID:_____Group:_____Clinic (circle) Yes or No

South Carolina Immunization Screening Questionnaire and Consent Form

Patient Information: (Patient to complete)

Patient Name:_____Date of Birth:_____Age:_____Phone#_____
Address:_____City:_____State:_____Zip:_____
Gender: M or F Which Vaccine(s) would you like to receive today?_____
Medical Conditions:_____ Enter Weight if less than 110 lbs:_____
Primary Care Physician:_____ Dr. Phone # if known_____
Primary Care Physician address- City:_____ State:_____ Zip:_____

Screening Questions for All Vaccines	**Yes**	**No**	**Don't Know**
Are you 12 years of age or older?			
Are you sick today?			
If yes to the above question: Do you have a new fever?			
Do you have a cough?			
Do you have diarrhea?			
Have you been vomiting?			
Have you ever fainted or felt dizzy after receiving a vaccine?			
Have you ever had a reaction after receiving a vaccine?			
Do you have a long-term health problem with heart or kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (diabetes) or anemia or another blood disorder?			
Do you have a long-term health problem with lung disease or asthma? Do you smoke?			
Do you have a weakened immune system b/c of HIV/AIDS or another disease that affects the immune system, long-term treatment with drugs such as high-dose steroids, or cancer treatment with radiation or drugs?			
Do you have allergies to medications, food (eggs), latex or any vaccine component(neomycin,formaldehyde,gentamicin,thimersol,bovine protein,phenol,polymxin,gelatin,baker's yeast or yeast)?			
Have you ever had a seizure disorder for which you are on seizure medications, a brain disorder, Guillan-Barre syndrome or other nervous system problems?			
Are you a parent, family member, or caregiver to a new born infant?			
For women: Are you pregnant or considering becoming pregnant in the next month?			
Did you bring your Immunization Record Card with you?			
Screening Questions in addition to the above for LIVE Vaccines	**Yes**	**No**	**Don't Know**
Are you currently on home infusions or weekly injections (such as Remicade, Humira, Enbrel, Cimzia, Simponi, Simponi Aria, Xeljanz, Orencia, Arava, Actemra, Cytoxan, Rituxan, adalimumab, infliximab or etanercept), high-dose methotrexate, azathioprine or 6-mercaptopuine, antivirals, anticancer drugs or radiation treatments?			
Have you received any vaccinations or skin tests in the past 4 weeks?			
Have you received a transfusion of blood, blood products or been given a medication called immune (gamma) globulin in the past year?			
Are you currently taking high-dose steroid therapy (prednisone >20mg/day) for longer than two weeks?			
For children receiving FluMist: Do you receive long term aspirin therapy or have a history of wheezing (2-4yo)?			
Have you had the following vaccines:	**Yes**	**No**	**Don't Know**
* Pneumococcal Vaccine- you need two different pneumococcal shots			
* Shingles Vaccine			
* Whooping Cough (Tdap) Vaccine			
Are you enrolled in any of Lake Murray Drug Co. adherence programs (auto refills, sync medications or Messaging- Text, Email, Phone)?			

Lake Murray Drug Co. is providing necessary vaccines to you in a safe and convenient setting in order to promote adherence to current immunization guidelines recommended by the CDC and ACIP. It does not take place of an ongoing relationship with your primary care provider to address your medical issues and other types of preventive care. We will provide your primary care physician with records of the vaccine(s) administered here to ensure your medical records are complete, but be sure to take your personal record with you during your next appointment.

I authorize the pharmacist to send copies of my vaccine documents to my primary care physician: **YES or NO**.

Failure to circle yes or no will result in the vaccine documents being sent to your primary care provider, if known, as state law and regulations require for my state.

I authorize the release of any medical or other information with respect to this vaccine(s) to my healthcare providers, Medicare, Medicaid or other third-party agents as needed and request payment of authorized benefits to be made on my behalf to Lake Murray Drug Co.

I acknowledge that if my insurance does not cover the cost of administering the vaccine at the pharmacy, then payment must be made at the time of the administration of the vaccine.
I acknowledge that my vaccination record will be shared with federal or state or city agencies for registry reporting.

I acknowledge that the pharmacist recommends that vaccinated patient should remain in the waiting area, for 15 minutes, after the administration of the immunization.

I acknowledge receipt of Lake Murray Drug Co. notice of privacy practices for protected health information.

I have read or have had read or explained to me, the Vaccination Information Sheet(VIS) regarding the vaccine(s). I understand the risks and benefits, and have been provided an opportunity to ask questions, which have been answered to my satisfaction. I wish to receive the vaccine(s). I consent to, or give consent for the pharmacist or pharmacy intern to administer the vaccine(s) and communicate the administration of the vaccine to my primary care physician listed above. I fully release discharge Lake Murray Drug Co., officers, and employees from any liability for illness, injury, loss, or damage which may result there from.

Patient Signature or legal guardian:_____**Date:**_____

If legal guardian print name here:_____

Signature of pharmacist or intern and supervising pharmacist who administered Vaccine(s) and provided the VIS to patient:

_____ License number:_____ NPI:_____ Date:_____