EST 1919

BOONE DRUGS INC.

OVER 100 YEARS • FAMILY OWNED AND OPERATED

Vaccine Intake Form

AVERY
436 Hospital Drive
Linville, NC 28646
P: 828-737-7476
F: 828-737-7479

MEDICAL ARTS
328 Mulberry Street SW
Lenoir, NC 28645
P: 828-758-2356
F: 828-754-4329

KING STREET
202 West King Street
Boone, NC 28607
P: 828-264-8929
F: 828-264-9231

GREENWAY
579 Greenway Road Suite 100
Boone, NC 28607
P: 828-355-3350
F: 828-264-8368

MOUNTAIN CITY
1641 South Shady Street
Mountain City, TN 37683
P: 423-727-0038
F: 423-727-6451

DEERFIELD
345 Deerfield Road
Boone, NC 28607
P: 828-264-3055
F: 828-264-0543

HALSEY
55 South Main Street
Sparta, NC 28675
P: 336-372-5599
F: 336-372-6190

VILLAGE
200 Shoppes on the
Parkway Road - Suite 54
Blowing Rock, NC 28605
P: 828-295-3482
F: 828-295-4835

NEW MARKET
245 New Market Center
Boone, NC 28607
P: 828-264-9144
F: 828-265-3201

HAMPTON
339 Highway 321
Hampton, TN 37658
P: 423-725-2327
F: 423-725-2353

CROSSNORE
4263 Linville Falls Hwy
Crossnore, NC 28616
P: 828-733-2486
F: 828-733-3581

EAST BURKE
300 Main Ave W
Hildebron, NC 28637
P: 828-397-3420
F: 828-397-3477

WARRENSVILLE
5121 NC Highway 88W
Warrensville, NC 28693
P: 336-384-3900
F: 336-384-4041

PLEASE PRINT IN BLACK INK

Last Name: _____ First Name: _____ M.I.: _____

Street Address: _____ City: _____ State: _____ Zip: _____ County: _____

Date of Birth: _____/_____/_____ Telephone Number: _____ Gender (circle): **Male** or **Female**

Mother's Maiden Name: _____ Mother's First Name: _____

(this information is used for the State vaccination registry)

Emergency Contact Information: Name: _____ Relation: _____ Phone #: _____

Primary Physician (name) **:** _____ City: _____ State: _____

Yes or **No** Have you shown any symptoms of COVID-19 and/or been around anyone with a confirmed case in the past 14 days?

Yes or **No** Are you sick today?

Yes or **No** Do you have allergies to medications, food, a vaccine component, or latex? (if yes, please list)

Yes or **No** Have you ever had a serious reaction after receiving a vaccination?

Yes or **No** Has a physician or other healthcare professional ever cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a medical (doctor's office or hospital) setting?

Yes or **No** Do you have cancer, Leukemia, AIDS, Rheumatoid Arthritis, or other immune system problems?

Yes or **No** In the past 3 months, have you taken medicine that affects your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease or psoriasis; or have you had radiation treatments?

Yes or **No** Have you ever had a seizure or other nervous system problem or Guillain-Barre Syndrome?

Yes or **No** Have you received **ANY vaccinations OR TB skin test in the past 4 weeks?**

Yes or **No** During the past year, have you received a blood transfusion, blood products, or been given immune (gamma) globulin or an antiviral drug?

Yes or **No** Do you have a history of fainting, particularly with vaccines?

Yes or **No** Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g. diabetes), anemia, or other blood disorder?

Yes or **No** **For women**: are you pregnant or do you plan to become pregnant in the next three (3) months?

Yes or **No** **For Tdap** and adult **Td**, do you have a cut, injury, puncture, or open wound that prompted you to get a tetanus shot? (Pharmacists can give even with an injury as long as they have a prescription)

I have read, or had explained to me, the most up-to-date Vaccine Information Statement per the CDC for the vaccine requested and understand the risks and benefits. I have been provided an opportunity to ask questions and they were answered to my satisfaction. I wish to receive the vaccine and hereby give my consent to receive the vaccine and for the provider to communicate the administration of the vaccine to my primary care practitioner, who is listed above. I have read the posted copy of the Patient's Privacy Policy (a copy is available upon request).

Signature of person to receive vaccine or their guardian:

Sign Here: _____ Date: _____/_____/_____

Office Use Only

Vaccine	Trade Name	Mfr.	Lot #	Expiration	Body Route	Body Site*	mL	VIS Date
Pneumococcal	Prevnar13 Pneumovax23				IM	RD LD	0.5	08/06/21 10/30/19
Influenza	Quadrivalent				IM	RD LD	0.5	08/06/21
Influenza	Quadrivalent High Dose				IM	RD LD	0.7	08/06/21
Influenza	QUAD FLUAD				IM	RD LD	0.5	08/06/21
Zoster	Shingrix				IM	RD LD	0.5	10/30/19
Zoster	Zostavax				SC	RUOT LUOT	0.65	10/30/19
XX	Diluent Adjuvant							
Tdap	Adacel Boostrix				IM	RD LD	0.5	08/06/21
Other					IM SC			

*RD = right deltoid, LD = left deltoid, RN = right nare, LN = left nare, BN = bilateral nares, SC = subcutaneous, RUOT = right upper, outer tricep, LOUT = left upper, outer tricep

☐ I have given this person a record of this immunization

☐ I have sent written proof of vaccination to this person's PCP

Administered by: _____ PharmD RPh RN CPhT

Date: _____/_____/_____

_____ Utilizing standing order with store's standing order provider

_____ Rx Attached/In Pharmacy file – Physician _____

(Initial)_____ NCIR entry completed (Date)____/_____/_____

(Initial)_____ Choosing a Doctor form given if appropriate

Payment processed in RX30 YES NO

NOTES

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