

Heritage Gateway Center
 1980 Easton Road, Suite 130
 Doylestown, PA 18901
 267.477.1010
 267.953.2778 Fax



**Vickery Vaccine
 SERVICES**

Universal Vaccination Form

- Home Visit
- COVID Test - Rapid Antigen
- COVID Test - PCR
- Flu Swab

Patient Data					
First Name	M.I.	Last Name	DOB	M/F	
Address			City	State	Zip
Phone		Email			
SS#			Driver's License #		

Medical Health Plan	
Medical Plan	
ID #	Group #

Prescription Health Plan	
Prescription Plan	Group #
ID #	PCN #

Patient Screening Questionnaire for Vaccination <small>If for any reason a question is not clear, please ask.</small>							
	Yes	No	Not Sure		Yes	No	Not Sure
1. Are you sick today?				8. Do you take cortisone, prednisone, other steroids, or anticancer drugs or any x-ray treatments?			
2. Do you have allergies to food, medication, or any vaccine?				9. Do you have a seizure or brain problem?			
3. Are you allergic to eggs?				10. During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin?			
4. Are you allergic to latex?				11. Are you pregnant or is there a chance you could become pregnant during the next 3 months?			
5. Do you have a history of Guillain-Barre syndrome?				12. Have you received any vaccination in the past 4 weeks? <i>(Please list)</i>			
6. Have you ever had a serious reaction after receiving a vaccination?							
7. Do you have cancer, leukemia, AIDS, or any other immune system problem?							

Primary Physician	
Physician/Group Practice	
Telephone #	Fax #

Agreement and Authorization for Release of Medical Information		
The undersigned does hereby authorize Pharmacy to release information to the primary physician identified above regarding vaccinations received today as well as verifies that the above information in correct and assumes full responsibility for payment should my insurance provider decline to pay for any reason.		
Patient/Guardian Signature	Patient/Guardian Name (Print)	Date
X		

Pharmacy Notations (Pharmacy Use Only)					
Vaccine	Mfg.	Lot#	Exp.	Inj. Site	By
Vaccine	Mfg.	Lot#	Exp.	Inj. Site	By
Vaccine	Mfg.	Lot#	Exp.	Inj. Site	By
Vaccine	Mfg.	Lot#	Exp.	Inj. Site	By

VIS Date	Payment Method
	<input type="checkbox"/> Check <input type="checkbox"/> Cash <input type="checkbox"/> Credit Card <input type="checkbox"/> Bill Insurance