iCareRx Pharmacy
1117 McLain Street
Newport, AR 72112

Name (as it appears on insurance card): ______________________________

Date of Birth: ____________________ Age: ______ Gender (circle one): Male / Female

Street Address: ______________________________

City: ____________________ State: ______ Zip Code: ____________

Family Doctor: ______________ Method of payment: Cash / Insurance (please provide card to pharmacy)

Screening Questions (if you answer yes, please explain below)
Please circle

- Are you sick today? Yes No
- Do you have allergies to medications, food, a vaccine component, or latex? Yes No
- Have you ever had a serious reaction after receiving a vaccination? Yes 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 No
- Do you have cancer, leukemia, AIDS, or any other immune system problem? Yes No
- Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments? Yes No
- Have you had a seizure or a brain or other nervous system problem? Yes No
- During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? Yes No
- For women: Are you pregnant or is there a chance you could become pregnant during the next month? Yes No
- Have you received any vaccinations in the past 4 weeks? Yes No

Consent and waiver: I consent to the staff to administer the medication(s) mentioned below. I have reviewed the vaccine information sheet (s) and understand the benefits and risks of receiving this medication and choose to assume this risk. I fully release and discharge the standing order physician (list physician) and the pharmacy, its affiliations and their officers, and employees from any illness, injury, loss, or damage that may result there from. I acknowledge that I have received a copy of the pharmacy's privacy policies according to HIPAA. I assign payment of authorized insurance benefits due to me to be paid to the pharmacy and will pay any copay or deductible that result. I consent the release of medical information when necessary for billing, reimbursement, and medical protocol. I also allow for the pharmacy to report any medications received to the appropriate state vaccine registry. I am aware that an immunization certified student pharmacist might be administering this medication. I agree to wait near the vaccination area for approximately 20 minutes to receive treatment in case of adverse reaction.

Signature of patient X: ______________________________ Date: ____________

Below is for pharmacy documentation

Medication: ______________ VIS Date: ________ Lot #: ____________ Exp Date: ________ Site: ____

Medication: ______________ VIS Date: ________ Lot #: ____________ Exp Date: ________ Site: ____

Administered by: ____________________ Title: ____________ Date Given: ____________