

Desired Administration Day



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Hepatitis A & B Vaccine (Twinrix) Administration Form

Welcome to LaConner Drug! Please complete this form so that we can ensure that our pharmacy file is accurate and up to date. Thanks!

_____/_____/_____
First Name M.I. Last Name M or F Date of Birth (MM/DD/YYYY)

Street Address (PO Box acceptable if given with physical address) City

_____(_____)_____
State Zip Code Home Phone **Email Address**

ALLERGIES: No Known Allergies **EGGS** Penicillin Neomycin Sulfa Gelatin Other: _____
MEDICAL CONDITIONS: No Known Medical Conditions High Blood Pressure Diabetes (Type I) Diabetes (Type II)
High Cholesterol Asthma Arthritis Depression Pregnancy (Due: _____) Other: _____

Did you receive a flu shot last year? YES NO | **Primary Care Doctor or Clinic:** _____
Do you get prescriptions filled by LaConner Drug? YES NO | **Do You Have GROUP HEALTH or STERLING?** YES NO

I have received the current Shingles vaccine information sheet, and/or have had explained to me the information on the sheet about the vaccine. I have had the chance to ask questions and they were answered to my satisfaction. I believe I understand the benefits/risk of the vaccine and ask that it is given to me or the person named above for whom I am authorized to make this request. I also received the Notice of Privacy Practices.

Signature **Date (MM/DD/YYYY)**

This is a vaccine requiring multiple doses to complete the series. Please make sure you fill in the **email address above so our pharmacists can send you a note when it is time for your next dose.**

If this is NOT your first dose please tell us how many doses along with the dates here:

Please also make sure to fill in the **Primary Care Doctor above so we may have that office update your chart to reflect the vaccination received today.**

Office use:
DATE OF VACCINATION: _____ Signature of Administrator: _____

MNF: _____ LOT# _____ EXP DATE: _____

SITE OF INJECTION: R OR L Deltoid Visit us online at www.laconnerdrug.com

Signature:

Email: