



IMMUNIZATION REQUEST

2016-17 NMSU LAS CRUCES



Southwest Pharmacy

2402 West Pierce Suite 1A, Carlsbad, NM 88220

(PH) 575-887-6611 (FAX) 575-887-0782 (EMAIL) southwestpharmacy@yahoo.com

PATIENT INFORMATION:

Patient Name: _____ D.O.B.: _____ Sex: M or F
 Address: _____ City: _____ State: _____ Zip: _____
 Phone: _____ Email: _____
 Physician: _____

BILLING INFORMATION CASH MEDICARE OTHER
PRESCRIPTION INSURANCE CARD Express: NMPSIA Express: State of NM



ID # _____



Circle One: Cardholder Spouse Child

* Immunizations are **NOT FREE** but offered as a benefit covered under Express prescription insurance with no co-payment required.

ANSWER QUESTIONS AND SIGN WAIVER:

- | | | |
|---|---|---|
| 1. Are you sick today? Fever? Diarrhea? | Y | N |
| 2. Do you have allergies to medications (neomycin, etc.), food (eggs), or any vaccine? | Y | N |
| 3. Have you ever had a serious reaction after receiving a vaccination? | Y | N |
| 4. Do you have cancer, leukemia, AIDS, or any other immune system problem? | Y | N |
| 5. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had x-ray treatments? | Y | N |
| 6. During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin? | Y | N |
| 7. For women: Are you pregnant or is there a chance you could become pregnant during the next month? | Y | N |
| 8. Have you received any vaccinations in the past 4 weeks? | Y | N |

I authorize Southwest Pharmacy Pharmacists to prescribe, administer and bill for immunizations requested and have provided accurate and current insurance information for insured dependents and/or agree to be financially liable for all vaccinations and administration fees for uninsured patients and/or their dependents. I acknowledge that the pre-vaccination questionnaire has been answered truthfully and honestly to the best of my ability. I have read and understand the Vaccination Information Statement (VIS) available at <http://www.immunize.org/vis/> . I authorize the release of these immunization records to my physician and the New Mexico Department of Health.

Patient Signature: _____ **Date:** _____

SELECT IMMUNIZATIONS YOU NEED BY CHECKING THE BOX TO THE LEFT OF THE NAME:

Vaccine	Date	Site	By	Vaccine	Lot #	Exp. Dt.	VIS date
<input type="checkbox"/>				Fluzone	UI678AE	6/30/2017	8/7/2015
<input type="checkbox"/>				Flucelvax	185886	4/30/2017	8/7/2015
<input type="checkbox"/>				Havrix	3RS99	3/21/2017	7/20/2016
<input type="checkbox"/>				Engerix	4AN45	5/6/2018	7/20/2016
<input type="checkbox"/>				TwinRix	L5SH5	9/27/2018	n/a
<input type="checkbox"/>				Gardasil 9	L036301	12/20/2017	4/15/2015
<input type="checkbox"/>				Menactra			10/14/2011
<input type="checkbox"/>				Pneumovax 23	M022086	10/9/2017	4/24/2015
<input type="checkbox"/>				Pprevnar 13	N05077	9/30/2017	2/27/2013
<input type="checkbox"/>				Adacel	U5468AA	9/30/2018	2/24/2015
<input type="checkbox"/>				Zostavax			10/6/2009
<input type="checkbox"/>							

Prescribed By: _____