TRIAD CARE
Health Care That Saves

Vaccine Administration Record

Last Name: _____ First Name: _____ MI: ____ DOB: ____/____/_____

Gender: ___ M ___F Phone Number: _____ Email: _____

Address: _____ City: _____ State: ____ Zip: _____

Allergies: _____

Primary Care Provider: _____ Phone: _____ Fax: _____

Provider Address: _____ City: _____ State: ____ Zip: _____

Screening Questions

Have you ever had a severe reaction to previous vaccines or a history of fainting with vaccines?	___YES	___NO
Do you have any allergies to medications, food, latex, yeast, eggs, gelatin, neomycin, or thimerosal?	___YES	___NO
Has a health care provider cautioned / warned you about receiving vaccines outside of a medical setting?	___YES	___NO
Are you sick today, or do you currently have a fever, diarrhea, vomiting, or infection?	___YES	___NO
Have you had a seizure or other nervous system problem or a history of Guillain-Barré syndrome?	___YES	___NO
If you are only receiving an influenza vaccine (flu shot), please proceed to the next section.		
Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	___YES	___NO
Do you have any CHRONIC health conditions? If yes, please list:	___YES	___NO
During the past year have you received a blood transfusion, gamma globulin, or an antiviral drug?	___YES	___NO
In the past 3 months have you taken medications that weaken your immune system? (Medications include cortisone, prednisone, anticancer drugs, or radiation treatments)	___YES	___NO
Have you received any vaccinations or TB skin test within the last 4 weeks?	___YES	___NO
For Women: Are you are pregnant or is there a chance you may become pregnant within the next month?	___YES	___NO
For Tdap: Do you have a cut, injury or puncture wound that prompted you to get vaccinated?	___YES	___NO

Billing Information & Consent

I hereby authorize Triad Care, Inc. to bill insurance or Medicare information listed below on my behalf. I request payment of authorized benefits be made to Triad Care, Inc. for the vaccine(s) listed below and administration as furnished to me by Triad Care, Inc. I authorize any holder of medical information about me to release to the insurance listed and its agents any information needed to determine these benefits payable for related services.

Insurance: _____ Subscriber ID: _____ Group: _____

Primary Policy Holder's Name: _____ (Primary Holder = First person listed on card)

Primary Policy Holder's D.O.B.: ___/___/_____ Insurance Phone Number: _____

I hereby certify that the foregoing history is true and complete to the best of my knowledge, and I have received and read the "Vaccine Information Statement" from the CDC, have had an opportunity to ask questions that were answered to my satisfaction, and do wish to receive the vaccination(s) fully understanding the risks and the benefits. I hereby consent to the administration of the vaccine(s). I fully release and discharge the standing order physician and Triad Care, Inc., its affiliations and their officers, and the employees from any illness, injury, loss, or damages that may result there from. I acknowledge that I have received a copy of Triad Care's privacy policies according to HIPAA. I assign payment of authorized insurance benefits due to me to be paid to Triad Care, Inc. and will pay any co-pay or deductible that result. I consent to the release of medical information when necessary for billing, reimbursement, and medical protocol. I certify I am at least 18 years old and hereby give my consent to Triad Care, Inc. to administer the vaccine stated below. If under 18 years old signature by parent or guardian required. I agree to wait near the vaccination area for approximately 15 minutes to receive treatment in case of adverse reaction.

I understand that my health insurance company may deny payment for the services of this immunization. If my health insurance company denies payment, I agree to be personally responsible for the full amount due. I understand that if my health insurance company makes a partial payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies.

Signature of Patient or Guardian: _____ Date: ____/____/_____

For Triad Care, Inc. Use Only

Vaccine(s)				Dose (mL)	Route (IM, SQ)	Site Given (RD, LD)	VIS Provided (Yes, No)
Vaccine Type	Manufacturer	Lot #	Expiration				

Immunizer: _____ Date Administered: _____