Flu Shots
Monday, September 24 from 10am – 12pm
Town Hall Board Room

Bayboro Pharmacy can bill insurance. MOST insurance companies cover flu shots with zero cost to patients. The cash price is $24.99.

In order for Bayboro Pharmacy to bill insurance, they will need a photo ID and a copy of the patient's insurance card. (Town Hall can make these copies for you)

I am attaching a copy of the Vaccine Administration Record that is required to be completed.

We will have some on hand, but in order to save time, you may want to complete them ahead of time.

We're also hoping to get a head count.

Please email admin@townoforiental.com with the subject line **FLU SHOTS** and a **number of those wishing to participate**, so we can help the pharmacy ensure they have enough vaccine on hand.

Vaccine Administration Record

Bayboro Pharmacy
702 Main St
Bayboro, NC 28515-9634
Phone: (252) 745-5539 Fax: (252) 745-5797

Name: _____ Male: _____ Female: _____ Date of Birth: _____

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

Phone: _____ Allergies: _____ Mother's Maiden _____ Race: _____

Primary Care Physician: _____ Office Phone Number: _____

Screening Questions

1.	Are you sick today?	Yes	No
2.	Do you have allergies to medications, food, eggs, yeast, a vaccine component, or latex?	Yes	No
3.	Have you ever had a serious reaction after receiving a vaccination?	Yes	No
4.	Has any physician or other healthcare professional ever cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a medical setting?	Yes	No
5.	Do you have a long-term health problem such as heart disease, lung disease, liver disease, asthma, kidney disease, diabetes, anemia or other blood disorder?	Yes	No
	a.) Do you smoke?	Yes	No
6.	Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem? Have you been diagnosed with rheumatoid arthritis, ankylosing spondylitis, Crohn's disease, herpes, or cold sores?	Yes	No
7.	In the past 3 months, have you taken medications that weaken your immune system such as cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?	Yes	No
8.	Have you had a seizure or a brain or other nervous system problem or Guillain Barre?	Yes	No
9.	During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or antiviral drug (including acyclovir famciclovir, valacyclovir)?	Yes	No
10.	For women: Are you pregnant or is there a chance you could become pregnant during the next month?	Yes	No
11.	Have you received any vaccinations or TB skin test in the past 4 weeks?	Yes	No
12.	Do you have a history of fainting, particularly with vaccines?	Yes	No
13.	**For Tdap and adult Td:** Do you have a cut, injury, puncture or open wound that prompted you to get a tetanus shot?	Yes	No
14.	**For Zoster:** Have you had a past reaction to gelatin or triple antibiotic ointment?	Yes	No

Consent

I have read, or have had read to me, the written information regarding the vaccine(s) being administered. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) being administered and have received a copy of a current Vaccine Information Sheet. I certify that I am at least 18 years old and hereby give my consent to the pharmacists of this Mutual Member Drug Store to administer the vaccine(s). If under 18 years old signature by parent or guardian is required. I, on behalf of myself, my heirs, executors, personal representatives, agents, successors, and assigns hereby agree to release, indemnify, and hold harmless Mutual Drug, its subsidiaries, divisions, affiliates, agents, officers, directors, contractors, and employees from any and all claims arising out of, in connection with, or in any way related to the administration of the vaccine(s).

I agree to wait near the vaccination location for approximately 15 minutes for observation by the pharmacist.

Name (print) _____ Signature _____ Date _____

Administration (Pharmacist Use Only)

Vaccine	Product Name	Manufacturer	Lot	Exp Date	Dose	Site of Injection	Date of VIS	Signature of administrator of vaccine
Influenza (TIV)	Fluzone	Sanofi			0.5 ml	LD RD	8/17/2015	
Pneumococcal Polysaccharide (PPSV23)	Pneumovax 23	Merck			0.5 ml	LD RD	10/6/2009	
Pneumococcal Conjugate (PCV13)	Prevnar	Pfizer			0.5 ml	LD RD	2/27/2013	
Herpes Zoster	Zostavax	Merck			0.65 ml	LTSC RTSC	10/6/2009	
Hepatitis B (Age 20+)	Engerix - B (Adult)	GSK			1 ml	LD RD	2/2/2012	
Influenza	Fluzone High Dose	Sanofi			0.5 ml	LD RD	8/7/2015	
Influenza QID	Fluzone Quad	Sanofi			0.5 ml	LD RD	8/7/2015	
Tetanus-Diphtheria (Td)	Tenivac	Sanofi			0.5 ml	LD RD	2/24/2015	
Tetanus, Diphtheria Toxoids & Acellular Pertussis (Tdap)	Boostrix	GSK			0.5 ml	LD RD	2/24/2015	