

Desired Administration Day

Please select your store



32170 State Route 20
Oak Harbor, WA 98277
360.675.6688 P
360.675.1563 F
www.islanddrug.com
wecare@islanddrug.com

11042 State Route 525 #130
Clinton, WA 98236
360.341.3885 P
360.341.3886 F
www.islanddrug.com
wecare.south@islanddrug.com

Hepatitis A & B Vaccine (Twinrix) Administration Form

Welcome to Island 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 Sulfa Neomycin 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 Island Drug? YES NO | **Do You Have GROUP HEALTH or STERLING?** YES NO

I have received the current Hepatitis A&B 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.islanddrug.com

Signature:

Email: