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
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wecare.south@islanddrug.com

Hepatitis B Vaccine (Engerix-B Recombivax) 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 B 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: