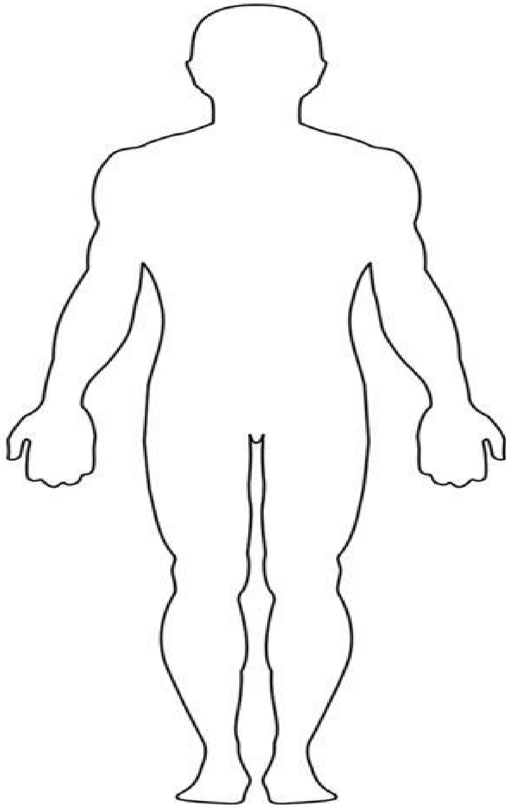
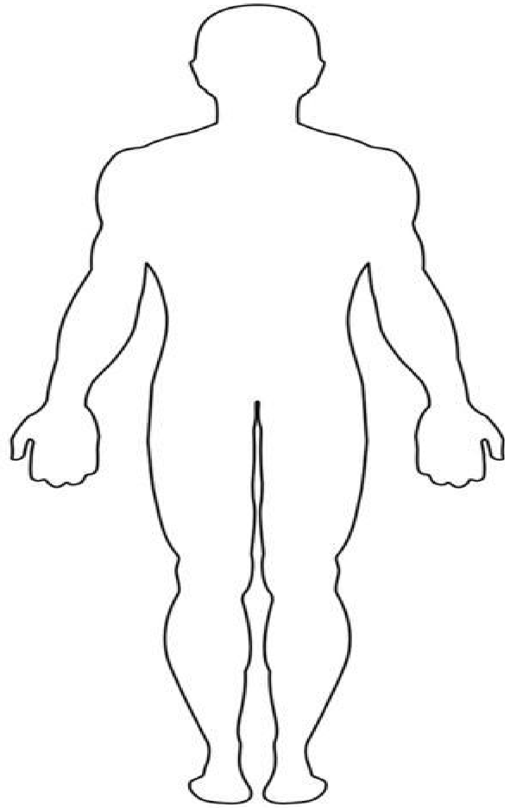
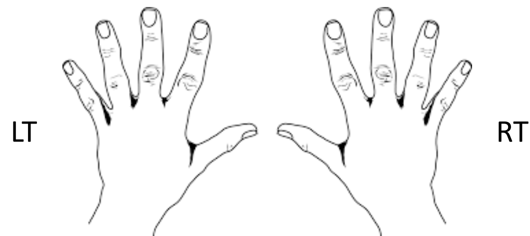
NAME: ______________________ DOB: ______________________

PHARMACY: ______________________ DATE: ______________________

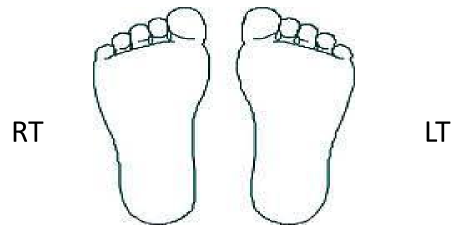
FRONT **BACK**





LT  RT

BACK OF HANDS

RT  LT

BOTTOMS OF FEET

OFFICE USE ONLY

Weight: ____________ HT: ___________ BMI: ________B/P: _____________ P: __________ Resp: ___________

COVID Vac: ______________ Date #1: ______________ Date #2:______________ Date #3: ______________

Flu Shot: YES/NO Date: ________________ Pneumonia Vac:_________ Date: _______________

Any Tobacco Products: ________________________ What/How Much: ____________________________

ORT: _______

CHART # ____