ASTHMA and ALLERGY INSTITUTE

Vaccine Order Form

Date of Order: _____

Patient Name: _____ Date of Birth:_____

Number of Vails: _____

How often are you taking the Injection: _____ Date of last Injection:_____

Any reaction at the Injection Site: Yes____ No_____

If Yes describe reaction: _____

_____

_____

Current Epi Pen: Yes ____ No____

Mail ____ (or) Pick up at office____

You may email or fax this form:

e-mail: ljcallergy@aaimobile.com

Fax: 251-304-0262

Questions? Call 251-304-0042