Vaccine Administration Record

Patient Name		Date of Birth	Gender
Address		Allergies	
City	State	Zip	Phone Number
Primary Care Prvider (PCP)	PCP Address		PCP Phone Number

Screening Question	YES	NO
1. Are you feeling sick today ?	☐	☐
2. Do you have any allergies to medication, food (eggs), latex, or a vaccine component (gelation, neomycin, polymyxin, yeast, polyethylene glycol, thimerosal)? USE dermal fillers? Plase List	☐	☐
3. Have you ever experienced fainting of had an allerigc reaction after receiving vaccination?	☐	☐
4. Do you have a long-term health problem such as heart disease, lung disease, liver disease, asthma, kidney disease, metabolic disease (e.g. diabetes) anemia or other blood disorder?	☐	☐
5. 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?	☐	☐
6. 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?	☐	☐
7. Have you had a seizure, or a brain or other nervous system problem, or Guillain-Barre?	☐	☐
8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? In the past 90 days, have you received passive antibody therapy	☐	☐
9. Do you have a bleeding disorder, history of or a risk factor for a blood clotting disorder? Are you taking a blood thinner?	☐	☐
10. Has any physician or other healthcare professional ever cautioned or warned you vaccines or receiving vaccines outside of a physican's office or hospital?	☐	☐
11. Are you pregnant or breast feeding?	☐	☐
12. For Tdap/Td: Do you have an open wound, puncture or tissue tear that prompted you to get a tetanus shot?	☐	☐

Vaccine Needed (check all that apply - circle option where applicable):

☐ Hepatitis A	☐ Hepatitis B	☐ Hepatitis A&B	☐ Human Papillomavirus	☐ Influenza	☐ Meningococcal (ACWY or B)
☐ Pneumococcal (13,15,20 or 23)	☐ Tetanus & Diphtheria	☐ Tetanus, Diphtheria & Pertussis	☐ Herpes Zoster (Shingles)	☐ COVID-19	☐ Other :

☐ I understand the benefits and risks of the vaccine as described in the (EUA/VIS), a copy of which I was provided with this Consent from. in have had a chance to ask questions that were answered to my satisfaction. I request the vaccine to be given to me or the person named above, a minor for whom I represent that I am a authorized to sign that consent form.

☐ I agree to stay in the vaccine administration area for fifteen (15) minutes or longer if indiated by te vaccine administrator after receiving my vaccine to ensure that no immediate adverse reactions occur.

Patient/Guardian Signature : Date :

***** *PHARMACY STAFF USE ONLY :*

Vaccine Given	Route	Dose	Manufacturer	Lot#	Exp. Date	Date on VIS

Name & Title of Vaccine Administrator : Date Vaccine and VIS Given :