Vaccine Administration Record

Patient Name	Date of Birth	Gender

Address	Allergies

City	State	Zip	Phone Number

Primary Care Provider (PCP)	PCP Address	PCP Phone Number

Screening Questions	YES	NO
1. Are you feeling sick today?	☐	☐
2. Do you have any allergies to medication, food (eggs), latex, or a vaccine component (gelatin, neomycin, polymyxin, yeast, polyethylene glycol, thimerosal)? Use dermal fillers? Please list:_____	☐	☐
3. Have you ever experienced fainting or had an allergic reaction after receiving a 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 about receiving certain vaccines or receiving vaccines outside of a physician's office or hospital?	☐	☐
11. Are you pregnant or breastfeeding?	☐	☐
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)	☐ Other: _____
☐ Pneumococcal (13, 15, 20 *or* 23)	☐ Tetanus & Diphtheria	☐ Tetanus, Diphtheria & Pertussis	☐ Herpes Zoster (Shingles)	☐ COVID-19	☐ RSV	☐ 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 Form. I have had a chance to ask questions that were answered to my satisfaction. I request the vaccine to be given to me or to the person named above, a minor for whom I represent that I am authorized to sign this Consent Form.

☐ I agree to stay in the vaccine administration area for fifteen (15) minutes or longer if indicated by the 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:* _____