

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						
1. Are you feeling sick today?						YES <input type="checkbox"/>
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: _____						NO <input type="checkbox"/>
3. Have you ever experienced fainting or had an allergic reaction after receiving a vaccination?						<input type="checkbox"/>
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?						<input type="checkbox"/>
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?						<input type="checkbox"/>
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?						<input type="checkbox"/>
7. Have you had a seizure, or a brain or other nervous system problem, or Guillain-Barre?						<input type="checkbox"/>
8. <i>During the past year</i> , have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? <i>In the past 90 days</i> , have you received passive antibody therapy?						<input type="checkbox"/>
9. Do you have a bleeding disorder, history of or a risk factor for a blood clotting disorder? Are you taking a blood thinner?						<input type="checkbox"/>
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?						<input type="checkbox"/>
11. Are you pregnant or breastfeeding?						<input type="checkbox"/>
12. For Tdap/ Td: Do you have an open wound, puncture or tissue tear that prompted you to get a tetanus shot?						<input type="checkbox"/>

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

<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Hepatitis A&B	<input type="checkbox"/> Human Papillomavirus	<input type="checkbox"/> Influenza	<input type="checkbox"/> Meningococcal (ACWY or B)	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Pneumococcal (13, 15, 20 or 23)	<input type="checkbox"/> Tetanus & Diphtheria	<input type="checkbox"/> Tetanus, Diphtheria & Pertussis	<input type="checkbox"/> Herpes Zoster (Shingles)	<input type="checkbox"/> COVID-19	<input type="checkbox"/> RSV	<input type="checkbox"/> 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: _____