

Vaccine Administration Record

Name: _____ Gender: _____ Date of Birth: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone: _____ Primary Care Physician Name and Address: _____
 Allergies: _____ Medicare # (including letters): _____
 Ethnicity (optional): Caucasian _____ African American _____ Hispanic _____ Asian _____ American Indian _____ Other _____

Screening Questions

- | | | |
|--|-----|----|
| 1. Are you sick today? | YES | NO |
| 2. Do you have allergies to medications, food, eggs, yeast, a vaccine component, or latex? | YES | NO |
| 3. Have you ever had a serious reaction after receiving a vaccination, or has any physician or other healthcare professional ever cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a medical setting? | YES | NO |
| 4. Have you had a severe allergic reaction to anything? | YES | NO |
| 5. Are you pregnant or breastfeeding, or is there a chance you could become pregnant in the next 14 days? | YES | NO |
| 7. 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, herpes, or cold sores? | YES | NO |
| 8. 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? | YES | NO |
| 9. Have you had a seizure or a brain or other nervous system problem or Guillain Barre? | YES | NO |
| 10. Do you have a history of fainting, particularly with vaccines? | YES | NO |
| 11. For Tdap and adult Td: Do you have a cut, injury, puncture or open wound that prompted you to get a tetanus shot? | YES | NO |
| 12. For COVID: Have you been ill or recovered from a COVID infection or had antibody therapy in the last 3 months? | YES | NO |
| 13. For COVID: Have you had a COVID vaccine before? | YES | NO |
- If yes, Which Vaccine (circle one)? Moderna Pfizer Johnson&Johnson
 Date of last dose (if known): _____

I have received a Notice of Privacy Practice for HIPAA. I have read, or have had read to me, the EUA information for the COVID vaccine I am receiving. I have been able to ask questions about the vaccine, and all my questions have been answered to my satisfaction. I understand the benefits and risks of the vaccine. I consent to the administration of the vaccine requested. I understand that the vaccination information will be shared with the state immunization database. I agree to stay in the general area for 15-30 minutes after receiving my vaccination in case any immediate reactions occur. If I experience any side effects, I am responsible for following up with my physician at my expense. On behalf of myself, my heirs, and my personal representatives, I hereby release the pharmacy that is administering the vaccine(s); the subsidiaries and affiliates of the pharmacy; the respective directors, officers, employees, and agents of the pharmacy and its subsidiaries and affiliates; and the owner and/or operator of the clinic site and its directors, officers, employees, and agents from any and all liability that might arise from this vaccination.

Name (print) _____ Signature _____ Date _____

PHARMACY USE ONLY BELOW THIS LINE

VACCINE(S): COVID-19 FLU Td Tdap PNEUMONIA SHINGRIX OTHER



LD or RD

 Signature of vaccine administrator Site of Injection
 By signing as administrator you are confirming that contraindications and side effects have been reviewed and a current VIS was provided to the patient receiving the vaccine.