Vaccine Administration Record

Name: _____ Male: _____ Female: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Allergies: _____ Race: _____

Primary Care Physician: _____ Office Phone Number: _____

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?	Yes	No
4.	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
5.	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?	Yes	No
6.	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
7.	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
8.	Have you had a seizure or a brain or other nervous system problem or Guillain Barre?	Yes	No
9.	During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or antiviral drug (including acyclovir famciclovir, valacyclovir)?	Yes	No
10.	For women: Are you pregnant or is there a chance you could become pregnant during the next month?	Yes	No
11.	Have you received any vaccinations or TB skin test in the past 4 weeks?	Yes	No
12.	Do you have a history of fainting, particularly with vaccines?	Yes	No
13.	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
14.	For Zoster: Have you had a past reaction to gelatin or triple antibiotic ointment?	Yes	No
15.	Have you had a COVID Vaccine in the past 2 months OR been diagnosed with COVID in the past 3 months?	Yes	No

Consent

I have read, or have had read to me, the written information regarding the vaccine(s) being administered. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) being administered and have received a copy of a current Vaccine Information Sheet. I, on behalf of myself, my heirs, executors, personal representatives, agents, successors, and assigns hereby agree to release, indemnify, and hold harmless Prescription Shoppe, Inc, its subsidiaries, divisions, affiliates, agents, officers, directors, contractors, and employees from any and all claims arising out of, in connection with or in any way related to the administration of the vaccine(s). I certify that I am at least 18 years old and hereby give my consent to the pharmacists of Prescription Shoppe, Inc to administer the vaccine(s). If under 18 years old signature by parent or guardian is required. I agree to wait near the vaccination location for approximately 15 minutes for observation by the pharmacist.

Name (print) _____ **Signature** _____ **Date** _____

Administration (Pharmacist Use Only)

Vaccine	Product Name	Manufacturer	Lot	Exp Date	Dose	Site of Injection	Date of VIS	Signature of Administrator of Vaccine
Influenza (TIV)	Flucelvax/Fluad	Seqirus			.5 ml	LD RD	8/6/2021	
Pneumococcal Polysaccharide (PPSV23)	Pneumovax 23	Merck			.5 ml	LD RD	10/30/2019	
Pneumococcal Conjugate (PCV13/PCV20)	Prevnar13/Prevnar20	Pfizer			.5 ml	LD RD	5/12/2023	
Herpes Zoster	Shingrix	GSK			.5 ml	LD RD	2/4/2023	
Hepatitis B (Age 20+)	Engerix - B (Adult)	GSK			1 ml	LD RD	5/12/2023	
Respiratory Syns Virus (RSV)	Abrysvo	Pfizer			.5 ml	LD RD	7/24/2023	
Tetanus, Diphtheria Toxoids & Acellular Pertussis (Tdap)	Boostrix	GSK			.5 ml	LD RD	8/6/2021	
COVID-19	Spikevax/Comirnity	Moderna			0.5ml	LD RD	9/2023	