Vaccine Administration Record

Peoples Drug Store, Inc.
7869 Main St
Houma, LA 70360-4461
Phone: (985) 873-8526 Fax: (985) 873-8541

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. Have you ever had an allergic reaction to a previous vaccine or any of the 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 receiving vaccines outside of a medical setting? Yes No
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem? Yes No
6. Have you ever tested positive for COVID-19 or has a doctor ever told you that you had COVID-19?
   * Have you received passive antibody therapy? Yes No
7. Do you have a bleeding disorder or are you taking a blood thinner? Yes No
8. Please list any allergies to food, pets, drugs, etc. Yes No
   Allergies:
9. For women: Are you pregnant or breastfeeding? Yes No
10. Do you have dermal fillers? 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 Peoples Drug Store, 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 Peoples Drug Store, 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
Covid-19	Moderna	Moderna			1st .5 ml	LD RD		
Covid-19	Moderna	Moderna			2nd .5 ml	LD RD		
						LD RD		
						LD RD		
						LD RD		
						LD RD		
						LD RD		
						LD RD		
						LD RD		