

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: LA Zip: _____
 Phone: _____ Allergies: _____ Race: _____
 Primary Care Physician: _____

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		
Covid-19	Moderna	Moderna			3rd .5 ml	LD RD		
Covid-19	Moderna	Moderna			Booster .25ml	LD RD		
Covid-19 BIVALENT booster	Moderna	Moderna			Booster 0.5 ml	LD RD		
						LD RD		
						LD RD		
						LD RD		
						LD RD		