Vaccine Administration Record

Vienna Drug Center
150 Maple Ave W
Vienna, VA 22180-5727
Phone: (703) 938-7111 Fax: (703) 938-5242

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

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

Phone:_____ Allergies: _____Race:_____

Medicare ID Number (Including ALPHA) if applicable:_____

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. Have you in the last 6 weeks had a seizure or a brain or nervous system problem or Guillain Barre?	Yes	No
5. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	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 Vienna Drug Center, 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 Vienna Drug Center 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/Legal Guardian_____ Date_____

Please wait in the pharmacy for 15 minutes after the vaccine is given for observation VIS given at time of administration

Administration (Pharmacy Staff Use Only)

Vaccine	Product Name	Manufacture	Lot	Exp Date	Site of Injection	Date of VIS	Signature of Administrator of Vaccine
Covid-19, mRNA	Spikevax	Moderna			LD RD		
Covid-19, mRNA	Comirnaty	Pfizer			LD RD		
Hep A, adult	Haririx 1,440u/ml 19+ yrs	GSK			LD RD		
Hep B, adult	Engerix-B Adult 20mcg/ml	GSK			LD RD		
Influenza Adjuvanted 65+ yrs	Fluad	Seqirus			LD RD		
Influenza	Afluria	Seqirus			LD RD		
Meningococcal B	Trumenba	Wyeth			LD RD		
Meningococcal conjugate, quad	Menquadfi	Sanofi-Pastor			LD RD		
Pneumococcal conjugate PCV20	Prevnar 20	Wyeth/Pfizer			LD RD		
Pneumococcal conjugate PCV21	Capvaxive	Durvet			LD RD		
RSV, bivalent	Abrysvo	Pfizer			LD RD		
Tdap	Boostrix	GSK					
Typhoid, VicPs	Typhim VI	Sanofi-Pastor			LD RD		
Zoster recombinate	Shingrix	GSK			LD RD		
Other					LD RD		

Place Label Here