

CHECK		VACCINE
		Flu
		Pneumovax 23
		Prennar 13
1st	2nd	Shingrix
		Tdap
OTHER-		



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Vaccine Questionnaire Form

Today's Date: _____ Name: _____

Address: _____

Phone/Cell#: _____ Birth date: _____

Medicare ID Number (Including ALPHA): _____

	Yes	No
1. Are you sick today?		
2. Do you have allergies to medications, food, a vaccine component, or latex? (If yes, please list)		
3. Have you ever had a serious reaction after receiving a vaccination?		
4. Have you had in the last 6 weeks: a seizure or other nervous system problem (i.e., Guillian-Barre Syndrome)? [influza/Tdap]		
5. For women: Are you pregnant or is there a chance you could become pregnant during the next month? [HPV/MenB/MMR/LAIV]		

I have read the adverse reactions associated with the vaccine I am about to receive. A copy of the vaccine manufacturer's drug information sheet is available on request. Furthermore, I have also had an opportunity to ask questions about these immunizations. I believe the benefits outweigh the risks and I voluntarily assume full responsibility for any reactions that may result. My medical record may be shared with my physician/insurance. I am requesting that the immunization(s) be given to me, or the person named below for whom I am the legal guardian. I, for myself, my heirs, executors, personal representatives and assigns, hereby release Vienna Drug Center, any retail site, grocery store, pharmacy, corporation, physician, and/or medical director and their respective affiliates, subsidiaries, divisions, directors, contractors, agents, employees, and their employees from any and all claims arising out of, in connection with or in any way related to my receipt of this or these immunization(s). Vienna Drug Center and the other aforementioned parties shall not at any time or to any extent whatsoever be liable, responsible, or in any way accountable for any loss, injury, death or damage suffered or sustained by any person at any time in connection with or as a result of this vaccine program or the administration of the vaccines described above.

X _____
 Signature / Legal Guardian _____ Date _____

 Print Name _____ Administrator _____

Vaccine: _____ Lot#: _____ Mfr: _____ Exp.Date: _____

VIS Date: _____ Site _____ Arm _____ Date VIS Given: _____

Vaccine: _____ Lot#: _____ Mfr: _____ Exp.Date: _____

VIS Date: _____ Site _____ Arm _____ Date VIS Given: _____

Please wait in the pharmacy for 15 minutes after the vaccine is given for observation

1. Are you sick today? *[all vaccines]*

There is no evidence that acute illness reduces vaccine efficacy or increases vaccine adverse events. However, as a precaution with moderate or severe acute illness, all vaccines should be delayed until the illness has improved. Mild illnesses (e.g., upper respiratory infections, diarrhea) are NOT contraindications to vaccination. Do not withhold vaccination if a person is taking antibiotics.

2. Do you have allergies to medications, food, a vaccine component, or latex? *[all vaccines]*

An anaphylactic reaction to latex is a contraindication to vaccines that contain latex as a component or as part of the packaging (e.g., vial stoppers, prefilled syringe plungers, prefilled syringe caps). If a person has anaphylaxis after eating gelatin, do not administer vaccines containing gelatin. A local reaction to a prior vaccine dose or vaccine component, including latex, is not a contraindication to a subsequent dose or vaccine containing that component. For information on vaccines supplied in vials or syringes containing latex, see www.cdc.gov/vaccinespubs/pinkbook/downloads/appendices/B/latex-table.pdf; for an extensive list of vaccine components, see www.cdc.gov/vaccinespubs/pinkbook/downloads/appendices/B/excipient-table-2.pdf.

People with egg allergy of any severity can receive any IIV, RIV, or LAIV that is otherwise appropriate for the patient's age and health status. With the exception of cIIIV and RIV (which do not contain egg antigen), people with a history of severe allergic reaction to egg involving any symptom other than hives (e.g., angioedema, respiratory distress), or who required epinephrine or another emergency medical intervention, the vaccine should be administered in a medical setting, such as a clinic, health department, or physician office; vaccine administration should be supervised by a healthcare provider who is able to recognize and manage severe allergic conditions.

3. Have you ever had a serious reaction after receiving a vaccination? *[all vaccines]*

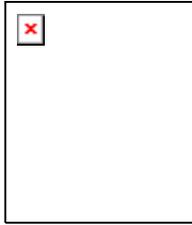
History of anaphylactic reaction (see question 2) to a previous dose of vaccine or vaccine component is a contraindication for subsequent doses. Under normal circumstances, vaccines are deferred when a precaution is present. However, situations may arise when the benefit outweighs the risk (e.g., during a community pertussis outbreak).

4. Have you had a seizure or a brain or other nervous system problem? *[influenza, Td/Tdap]*

Tdap is contraindicated in people who have a history of encephalopathy within 7 days following DTP/DTaP. An unstable progressive neurologic problem is a precaution to the use of Tdap. For people with stable neurologic disorders (including seizures) unrelated to vaccination, or for people with a family history of seizure, vaccinate as usual. A history of Guillain-Barré syndrome (GBS) is a consideration with the following: 1) Td/Tdap: if GBS has occurred within 6 weeks of a tetanus toxoid vaccine and decision is made to continue vaccination, give Tdap instead of Td if no history of prior Tdap; 2) Influenza vaccine (IIV/LAIV): if GBS has occurred within 6 weeks of a prior influenza vaccine, vaccination should generally be avoided unless the benefits outweigh the risks (for those at higher risk for complications from influenza).

5. For women: Are you pregnant or is there a chance you could become pregnant during the next month? *[HPV, IPV, MenB, MMR, LAIV, VAR]*

Live virus vaccines (e.g., MMR, VAR, LAIV) are contraindicated one month before and during pregnancy because of the theoretical risk of virus transmission to the fetus. Sexually active women in their childbearing years who receive live virus vaccines should be instructed to avoid pregnancy for one month following receipt of the vaccine. On theoretical grounds, IPV and MenB should not be given during pregnancy; however, it may be given if there is a risk of exposure. IIV and Tdap are both recommended



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Vaccine Administration Record for Children, Teens and Adults

Patient Name: _____

Birth Date: _____

Vaccine	Type of Vaccine	Date Given	Site	Vaccine			Vaccine Information Statement		Signature of Vaccinator
				Lot	Exp Date	Mfr.	Date on VIS	Date Given	
Human Papillomavirus (HPV) (give IM) 0, 2M, 6 months	Gardasil-9					Merck	8-6-21		
Hepatitis A&B (give IM) 0, 1, 6 months	Twinrix					GSK	7/20/16		
Hepatitis A (give IM) 0, 6-12 months	Havrix					GSK	07/28/20		
Hepatitis B (give IM) 0, 1-2 months, 6 months	Engerix B					GSK	08/15/19		
Influenza adjuvanted (high dose, IM, 65+) Yearly	FLUAD 65+ 2021-2022					Seqirus	8/6/21		
Influenza (Quadrivalent, IM, age 6 months and older) Yearly	Flu QUAD 2021-2022						8/6/21		
Meningococcal (MenACWY) (give IM) Once	Menactra (9 mos- 55)					SP	8/6/21		
Meningococcal Group B (give IM) 0, 6 months	Trumenba (10y-25y) Bexsero (10y-25y)					Pfizer	8/6/21		
Measles, Mumps & Rubella (MMR II) (give SC) Post-exposure prophylaxis w/in 72 hrs after exposure	MMR II					Merck	8/6/21		
Pneumococcal (PPSV23, Polysaccharide) (give SC or IM) 1 st dose b/w 19-64 yrs old 2 nd dose after 65 but 5 yrs from last PPSV23 dose	Pneumovax 23					Merck	10/30/19		
Pneumococcal 13-Valent (PCV13) (give IM) One dose given 1 yr from PPSV23	Prenar 13					Pfizer	8/6/21		
Tetanus, Diphtheria, Pertussis (give IM) Every 10 years	Boostrix Adolescent thru 65+					GSK	8/6/21		
Typhoid Injection When recommended	Typhim VI					SP	10/30/19		
Zoster (give IM) 50+ yrs old 0, 2-6 months	Shingrix					GSK	10/30/19		
Other									