Daly Drug Pharmacy
Vaccine Administration Record (VAR)

Name: _____
First Last Middle Initial

Address: _____

Phone:_____ **Date of Birth** _____/_____/_____ **Sex:** M _____ F _____
Month Day Year

Eligibility Questions:

1) **Which vaccines are you requesting today?**

Flu_____ Pneumonia_____ Tdap_____ Shingles_____

2) **Have you had this vaccine before?.....Yes No**
3) **Are you allergic to thimerosal containing products?.....Yes No**
4) **Are you allergic to chicken, eggs, or egg products?.....Yes No**
5) **Have you ever had a serious reaction to a vaccine?.....Yes No**
6) **Do you have a history of Guillain-Barre Syndrome?.....Yes No**
7) **Are you allergic to rubber or latex products? .....Yes No**
8) **Are you sick today?.....Yes No**
9) **Do you have long term health disorder? .....Yes No**
10) **Are you currently immunocompromised?.....Yes No**
11) **Have you received vaccinations in the past 4 weeks? .....Yes No**
12) **Are you pregnant or is there a chance you will be pregnant soon? .....Yes No**

I have received and read the information sheet(s) for the vaccination I wish to receive and have been given the opportunity to ask questions which were answered to my satisfaction. I accept that services may be rendered in a non-private setting. I agree to remain in the pharmacy or within the vicinity of the vaccinating pharmacist for at least 10 minutes after receiving vaccination**. I hereby consent to the administration of the vaccine(s) listed above to myself or the person named below for whom I am authorized to make this request.** Furthermore, I hereby release and forever discharge myself, my heirs, executors, administrators and assignees, Daly Drug and their employees, owners and representatives from any and all claims, demands, actions, and causes of action, which may result from participation in this program. I will communicate the information provided to me today about my vaccination to my primary care provider if I have one.

I understand that I am responsible for the cost of this vaccination if insurance does not fully or partially cover.

Signature:_____Date:_____

Pharmacy Use Only:

Date Vaccinated:_____Date on VIS:_____Date VIS Given:_____

Vaccine:_____MFR:_____Lot:_____Exp:_____

Administered by (And Title)_____