

Vaccine Administration Record

Ferndale Pharmacy
2057 Alder St
Ferndale, WA 98248-7727
Phone: (360) 325-4310 Fax: (360) 325-4320

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. 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. Preferred site of vaccination? Left or Right arm? | Left | Right |
| 5. Has any physician or other healthcare professional ever cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a medical setting? | Yes | No |
| 6. Do you have a long-term health problem such as heart disease, lung disease, liver disease, asthma, kidney disease, metabolic disease (e.g., diabetes) anemia or other blood disorder? | Yes | No |
| 7. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem? Have you been diagnosed with rheumatoid arthritis, ankylosing spondylitis, Crohn's disease, herpes, or cold sores? | Yes | No |
| 8. In the past 3 months, have you taken medications that weaken your immune system such as cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments? | Yes | No |
| 9. Have you had a seizure or a brain or other nervous system problem or Guillain Barre? | Yes | No |
| 10. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or antiviral drug (including acyclovir famciclovir, valacyclovir)? | Yes | No |
| 11. For women: Are you pregnant or is there a chance you could become pregnant during the next month? | Yes | No |
| 12. Have you received any vaccinations or TB skin test in the past 4 weeks? | Yes | No |
| 13. Do you have a history of fainting, particularly with vaccines? | Yes | No |
| 14. For Tdap and adult Td: Do you have a cut, injury, puncture or open wound that prompted you to get a tetanus shot? | Yes | No |
| 15. For Zoster: Have you had a past reaction to gelatin or triple antibiotic ointment? | 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 Ferndale Pharmacy, 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 Ferndale Pharmacy 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
Influenza (QIV)					.5 ml	LD RD	8/7/2015	
Pneumococcal Polysaccharide (PNE)		Merck			.5 ml	LD RD	5/12/23	
Respiratory Syncytial Virus (RSV)					.5 ml	LD RD	7/24/2023	
Herpes Zoster	Shingrix	GSK			.5 ml	LD RD	2/12/2018	
Hepatitis B (Age 20+)	Engerix - B (Adult)	GSK			1 ml	LD RD	7/20/2016	
Tetanus, Diphtheria Toxoids & Acellular Pertussis (Tdap)	Boostrix	GSK			.5 ml	LD RD	2/24/2015	
Covid-19		GSK			.5 ml	LD RD	8/31/2022	

Pharmacist Name (print) _____ Signature _____ Date _____