VAR - Vaccine Administration Record

Name: _____ Birth date: _____ Age: _____ Sex: M / F

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

Phone: _____ Emergency Contact Name & Phone: _____

Medicare ID# (including alpha): _____ Member ID: _____

Group #: _____ Bin #: _____ PCN #: _____ Insurance: _____

Please mark the vaccine(s) you are receiving today: **Required*

☐ Influenza (Flu) ☐ Shingles - **Dose #***: ____ ☐ Td/Tdap

☐ COVID-19 - **Dose #***: ____ ☐ Pneumococcal ☐ Other _____

Screening Checklist: The following questions will help us determine your eligibility to be vaccinated today.

1. Do you feel sick today? ☐ Yes ☐ No ☐ Don't know
2. Have you been diagnosed with or tested positive for COVID-19 in the last 21 days? ☐ Yes ☐ No ☐ Don't know
3. Do you have a history of allergic reaction or allergies to latex, medications, food or vaccines (examples: polyethylene glycol, polysorbate, eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal)? ☐ Yes ☐ No ☐ Don't know
   If yes, please list: _____
4. Have you ever had a reaction after receiving a vaccination, including fainting or feeling dizzy? ☐ Yes ☐ No ☐ Don't know
5. Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-Barré syndrome (a condition that causes paralysis) or other nervous system problem? ☐ Yes ☐ No ☐ Don't know
6. Have you received any vaccinations or skin tests in the past four weeks? If yes, please list: ☐ Yes ☐ No ☐ Don't know
   _____
7. Do you have any chronic health condition such as cancer, chronic kidney disease, immunocompromised, chronic lung disease, obesity, sickle cell disease, diabetes, heart disease?If yes, please list: _____ ☐ Yes ☐ No ☐ Don't know
8. For women: Are you pregnant or considering becoming pregnant in the next month? ☐ Yes ☐ No ☐ Don't know
9. Do you have a bleeding disorder or are you taking a blood thinner? ☐ Yes ☐ No ☐ Don't know
10. Do you have a condition that may weaken your immune system (e.g., cancer, leukemia, lymphoma, HIV/AIDS, transplant)? ☐ Yes ☐ No ☐ Don't know
11. Are you currently on home infusions, weekly injections such as Humira®, Remicade® or Enbrel®, high-dose methotrexate, azathioprine or 6-mercaptopurine, antivirals, anticancer drugs or radiation treatments? ☐ Yes ☐ No ☐ Don't know
12. Are you currently taking high-dose steroid therapy (prednisone > 20mg/day or equivalent) for longer than 2 weeks? ☐ Yes ☐ No ☐ Don't know
13. **For COVID-19 vaccine only:** Have you been treated with antibody therapy specifically for COVID-19 (monoclonal antibodies or convalescent plasma)? ☐ Yes ☐ No ☐ Don't know
14. **For COVID-19 vaccine only:** Have you had a previous dose of any COVID-19 Vaccine? If yes, please list which one and how many: _____ ☐ Yes ☐ No ☐ Don't know

Consent: Most commonly, reactions may be sore or tender arm at injection sit, or possibly fever, chills, headache or muscle aches. Symptoms usually last 24-48 hours. I release Daly Drug from responsibility of any reaction resulting from the injection and I take full responsibility to seek medical attention should more severe symptoms occur. I acknowledge I have no contraindications listed in the "Screening Checklist" that would prevent me from receiving a vaccination at this time. I authorize Daly Drug to release information and request payment. I certify the information given is correct and accurate in applying for payment under Medicare, Medicaid, or the HRSA COVID-19 Program for Uninsured Patients. I understand Daly Drug may be required to or may voluntarily disclose health information to my Primary Care Physician, my insurance plan, health systems and hospitals, and State or Federal registries for purposes of treatment, payment, or health care operations.

I have read, or had explained to me, the 2022-2023 Vaccine Information Statement for the vaccines I am consenting to receive and understand the risks and benefits of each.

Signature of Patient or Legal Guardian _____ Relation to Patient (if not patient) _____ Date _____

FOR PHARMACY USE ONLY

Vaccine Type	Vaccine			Date Given (mo/day/yr)	Route (IM, SQ)	Site Given (RA, LA)	Vaccine Information Statement	
	Lot #	Expiration	Manufacturer				Date on VIS	Date Given

Printed Name of Pharmacist Administering Vaccine _____ Pharmacist's Signature _____