VAR - Vaccine Administration Record

Name: _____ DOB: _____ Age: _____ Sex: M / F
Street Address: _____ City: _____ State: _____ ZIP: _____
Phone: _____ Emergency Contact Name & Phone: _____
Medicare ID (including alphabet): _____ Insurance Name: _____
ID #: _____ BIN #: _____ PCN #: _____ Group #: _____

Race: ☐ White ☐ Asian ☐ American Indian or Alaska Native ☐ Black or African American ☐ Unknown
☐ Native Hawaiian or Pacific Islander ☐ Other Race _____ ☐ Unable to report due to policy/law

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ethnicity ☐ Unable to report due to policy/law

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

☐ Influenza (Flu) ☐ COVID ☐ Shingles — **Dose #***: ____
☐ Pneumococcal ☐ Td/Tdap ☐ RSV ☐ 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) If yes, please list:	☐ Yes	☐ No	☐ Don't know
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 a seizure medication(s), a brain condition, Guillain-Barré syndrome (a condition that causes paralysis) or another 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. For women: Are you pregnant or considering becoming pregnant in the next month?	☐ Yes	☐ No	☐ Don't know
8. Do you have a bleeding disorder or are you taking a blood thinner?	☐ Yes	☐ No	☐ Don't know
9. Are you receiving 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
10. Are you currently taking high-dose steroid therapy (prednisone>20mg/day or equivalent) for longer than 2 weeks?	☐ Yes	☐ No	☐ Don't know
11. For COVID-19 vaccine only: Have you been treated with antibody therapy specifically for COVID-19, such as monoclonal antibodies or convalescent plasma?	☐ Yes	☐ No	☐ Don't know

12. If under 65, do you have any of the following risk factors for getting very sick with COVID-19? Check all that apply.

☐ Overweight or Obese ☐ Physical inactivity ☐ Smoking current or former ☐ Cancer ☐ Cerebrovascular disease ☐ Chronic kidney disease
☐ Chronic liver disease ☐ Chronic lung disease ☐ Cystic fibrosis ☐ Dementia or other neurological conditions ☐ Diabetes (type 1 or 2)
☐ Disabilities ☐ Heart conditions ☐ Hemoglobin blood disorders ☐ HIV ☐ Immunocompromised or weakened immune system
☐ Mental health conditions ☐ Pregnancy ☐ Solid organ or blood stem cell transplant ☐ substance use disorders ☐ Tuberculosis (TB)
Other _____

Consent: Most commonly, reactions may include a sore or tender arm at the injection site, fever, chills, headache, or muscle aches. Symptoms usually last 24–48 hours. I release Daly Drug from responsibility for any reaction resulting from the injection and I accept full responsibility for seeking medical attention if severe symptoms occur. I acknowledge that 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 that the information provided is correct and accurate in applying for payment under Medicare or Medicaid. I understand that 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 2026–2027 Vaccine Information Statement for the vaccines I am consenting to receive, and I understand the risks and benefits of each. (Zoster 2/4/22, Pneumococcal 5/29/25, Flu, Covid, Tdap, RSV 1/31/25)**

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

FOR PHARMACY USE ONLY

Vaccine Type	Vaccine			Date Vaccine and VIS Given (M/D/Y)	Route (IM, SQ)	Site Given (RA, LA)
	Lot #	Expiration	Manufacturer			

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