Springtown Pharmacy

Vaccine Administration Form

I. PATIENT INFORMATION

NAME: (Last) (First) (M.I.)		Drug Allergies:	
ADDRESS:	DATE OF BIRTH: (mm/dd/yyyy)	AGE:	SEX: ☐ Male ☐ Female
CITY: STATE: ZIP:	PHONE NUMBER:		
Primary Care Dr:	EMAIL:		

II. VACCINE SCREENING QUESTIONNAIRE

	YES	NO
Did you receive the seasonal influenza vaccine last year?		
Do you have a fever or are you feeling ill today?		
Do you have a serious allergy to eggs?		
Do you have other serious allergies? (If yes, please list):		
Have you ever had a serious reaction to a previous dose of flu vaccine?		
Have you ever had Guillain-Barré Syndrome within 6 weeks after receiving a flu vaccine?		
Do you have a blood clotting disorder or are you taking any blood thinning medication?		

III. VACCINE CONSENT

I have read or had explained to me the Vaccine Information Statement and understand the risks and benefits of the vaccine(s) I have elected to receive. All of the questions I have about the risks and benefits have been answered to my satisfaction. I give consent to Springtown Pharmacy and its authorized immunizers to administer the vaccination and bill my insurance, if applicable. I fully release and hold harmless Springtown Pharmacy and any of its agents, officers, directors and employees, including certified student immunizers and volunteers from liability for any claims related to the administration of the vaccine. I understand that I have been advised to wait near the vaccination area for approximately 15 minutes to receive treatment in case of adverse reaction.

_____ _____

PATIENT/LEGAL GUARDIAN SIGNATURE DATE

FOR ADMINISTRATIVE USE ONLY

VACCINE	ROUTE	DATE ADMINISTERED	VACC. MANF	LOT NUMBER & EXPIRATION DATE	VIS DATE
	Deltoid - IM / SQ L R	/ /			
	Deltoid - IM / SQ L R	/ /			
	Deltoid - IM / SQ L R	/ /			
VACCINE ADMINISTRATOR (Name & Title):					