VACCINE ADMINISTRATION RECORD (VAR) (Please complete the following):

Print Name:___________________________________ Date of Birth____/____/____

Street Address:____Phone#_______________
Physical address City zip code

Primary Care Physician:____________________________ ______________ ____
Print Name City State

Vaccination Requested/Given (Please Check One)

☐ Flu Shot (Influenza) ☐ Pneumonia Shot_________☐ Shingles (Zoster)
☐ Hib Haemophilus InflB ☐ Chicken Pox(Varicella) ☐ HPV(Gardasil)
☐ Hepatitis A ☐ Hepatitis B ☐ Combo Hepatitis A+B
☐ Td (Tetanus/Diptheria) ☐ Tdap (Tetanus/Diptheria/Pertussis)
☐ Meningococcal(Meninigitis) ☐ MMR (Measles/Mumps/Rubella) ☐___________________

1) Are you currently feeling ill or do you have a fever? --------------- No Yes_____________
2) Do you have allergies to Medications or food? ---------------------- No Yes_____________
3) Have you ever had a serious reaction or allergy to a Vaccination? No Yes_____________
4) Do you have any long-term health problems with Heart disease,
Lung disease, Asthma, Kidney disease, Diabetes? -------------- No Yes_____________
5) Do you or anyone you are in contact with have Cancer, AIDS
Leukemia or any other Immune Disorder? ----------------------- No Yes_____________
6) Do you take cortisone, prednisone, other steroids, anticancer drugs
or have had x-ray treatment recently? ---------------------------- No Yes_____________
7) Have you received any transfusions, blood products or been given A
medicine called immune(gamma)globulin within the last year? No Yes_____________
8) Have you received any vaccinations or planning on receiving any
more vaccinations within 4 weeks? ------------------------------- No Yes_____________
9) For Women: Are you pregnant or planning to become pregnant
within a short time? --- No Yes_____________
10) Do you have your personal immunization records with you? No Yes_____________
If you don't have a personal record, ask your healthcare provider to supply one for you.
Keep this record for future reference so that we may add to it and keep you current on vaccinations.

Vaccine Administration Consent: "I have received the Vaccine Information Statement and have read or have had explained to me the information in that sheet. I have had a chance to ask questions and they were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine. I understand that some or all of the information on this vaccination record is required by law to be reported to my physician listed above. I request and authorize the pharmacist to administer the vaccine to me"

Signature: ____**Date**: _____/_____/_____

****

(PHARMACY USE ONLY)

*Notes*___________________________________
____

*RPH INITIALS*_______

Date reported to patients Physician: ____/____/____
(report within 14 days)
fax / phone / other

Pharmacy Label
sig: should have inject(qty) (IM or SQ) into the (R or L) (Delt or Upper Arm)
Vaccine Lot#______, Exp date________

Use Pharmacist giving vaccine as provider