

**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)
- Tdap (Tetanus/Diphtheria/Pertussis)

- 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 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 \_\_\_\_\_

**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:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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*(PHARMACY USE ONLY)*

Notes \_\_\_\_\_  
\_\_\_\_\_

RPH INITIALS \_\_\_\_\_

Date reported to Alert: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

<b>Pharmacy Label</b>
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