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

Gender: _____

Vaccination Requested/Given (Please Check One)

☐ Flu Shot (Influenza) ☐ Pneumonia Shot ☐ Shingles (Zoster)

☐ Tdap (Tetanus/Diptheria/Pertussis) ☐ RSV (Respiratory Syncytial Virus)

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: ____/____/____

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