

VACCINE ADMINISTRATION RECORD

Name _____ Male _____ Female _____ Date of Birth _____
 Address _____ City _____ State _____ Zip _____
 Phone (____) _____ Social Security # _____ - _____ Medicare # (including letters) _____
 Allergies _____ Primary Care Physician and Phone Number _____
 Ethnicity (optional): Caucasian _____ African American _____ Hispanic _____ Asian _____ American Indian _____ Other _____

Screening Questions

- | | | |
|--|-----|----|
| 1. Are you sick today? | YES | NO |
| 2. Do you have any allergies to medications, foods (e.g. eggs), latex, or a vaccine component (e.g. gelatin, neomycin, polymyxin, yeast, thimerosal, etc.)? If yes, please list: _____ | YES | NO |
| 3. Have you ever had a serious reaction (including fainting) after receiving a vaccination? (If fainting, need vagal precautions built into protocol with triage and treatment recommendations should this occur at pharmacy). | YES | NO |
| 4. Do you have a long-term health problem such as heart disease, lung disease, liver disease, asthma, kidney disease, metabolic disease (e.g., diabetes) anemia or other blood disorder? (If so, these need to be addressed in protocol based on current accepted guidelines). | YES | NO |
| 5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem? Have you been diagnosed with rheumatoid arthritis, ankylosing spondylitis, Crohn's disease? | YES | NO |
| 6. In the past 3 months, have you taken medications that weaken your immune system, such as cortisone, prednisone, other steroids or anticancer drugs, or have you had radiation treatments? | YES | NO |
| 7. Have you had a seizure, or a brain or other nervous system problem, or Guillain-Barre? | YES | NO |
| 8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? (Response needs to be addressed in protocol.) | YES | NO |
| 9. For women, are you pregnant or is there a chance you could become pregnant during the next month? (Protocol needs to address for specific vaccines.) | YES | NO |
| 10. Has any physician or other healthcare professional ever cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a physician's office or hospital? (If answer is yes, this is a hard stop). | YES | NO |
| 11. Have you received any vaccinations in the past 4 weeks? (Question not required for inactivated injectable influenzas but is for all other immunizations including live attenuate intranasal influenza.) | YES | NO |
| 12. For Tdap and adult Td (ONLY). Do you have an open wound, puncture or tissue tear that prompted you to get a tetanus shot? (If answer is yes, this is a hard stop). | YES | NO |

I have read, or have had read to me, the written information regarding the vaccine(s) marked below. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) being administered and have received a copy of a current Vaccine Information Sheet for each vaccine I am receiving today. I, on behalf of myself, my heirs, executors, personal representatives, agents, successors, and assigns hereby agree to release, indemnify and hold harmless Mutual Drug, its subsidiaries, divisions, affiliates, agents, officers, directors, contractors, and employees from any and all claims arising out of, in connection with, or in any way related to the administration of the vaccine(s) marked below. I certify that I am at least 18 years old and hereby give my consent to the pharmacists of the Mutual Member Drug Store to administer the vaccine(s) marked below. If under 18 years old signature by parent or guardian required. **I AGREE TO WAIT NEAR THE VACCINATION LOCATION FOR APPROXIMATELY 15 MINUTES FOR OBSERVATION BY A MUTUAL DRUG MEMBER PHARMACIST.**

 Name (print) _____ Signature _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Name (print) _____ Signature _____ Date _____

Vaccine to be administered: Influenza Pneumococcal Polysaccharide Pneumococcal Conjugate Herpes Zoster Hepatitis A
 Hepatitis B Meningococcal Polysaccharide Meningococcal Conjugate Meningococcal B Tetanus diphtheria
 Human Papillomavirus Tetanus and Diphtheria Toxoids and Pertussis Tetanus and Diphtheria Toxoids and Acellular Pertussis
 Tetanus Toxoid

- | | | |
|---|----------------------------|--|
| 1. _____
Vaccine name & manufacture | _____
Lot # & exp. date | _____
Dose |
| LD _____ or RD _____
Site of Injection | _____
Date of VIS | _____
Signature of administrator of vaccine |
| 2. _____
Vaccine name & manufacture | _____
Lot # & exp. date | _____
Dose |
| LD _____ or RD _____
Site of Injection | _____
Date of VIS | _____
Signature of administrator of vaccine |

Store Stamp:

Primary Care MD Notified: Date: _____
 Phone _____ Fax _____ RPh/Tech: _____