Vaccine Administration Record C

Kaup Pharmacy
Phone: 1(800) 686-2314

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Appendix E
Updated: 10/27/2021

Name: _____ Male: _____ Female: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Allergies: _____

How would you best describe yourself? (Please select all that apply)
☐ American Indian / Alaska Native ☐ Asian ☐ Black or African American ☐ Pacific Islander ☐ White ☐ Other ☐ Prefer not to say

Are you Hispanic? ☐ Yes ☐ No ☐ Prefer not to say

Please indicate below which vaccination(s) you would like to receive today with a 'X' in the square(s) on the bottom left side of this form.

Screening Questions

1.	The vaccine(s) you are receiving today, have you ever received it / them before?	☐ Yes	☐ No
2.	Are you feeling sick today or experiencing a moderate to high fever today?	☐ Yes	☐ No
3.	Do you have any allergies to medications, food (i.e., eggs, shellfish), latex, or a vaccine component (e.g., yeast, gelatin)? If yes, please circle above or list allergy: _____	☐ Yes	☐ No
4.	Have you ever had a serious reaction after receiving a vaccination?	☐ Yes	☐ No
5.	Do you have a history of fainting or dizziness, particularly with vaccine administration?	☐ Yes	☐ No
6.	Has any physician or other healthcare professional ever cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a medical setting?	☐ Yes	☐ No
7.	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?	☐ Yes	☐ No
8.	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, herpes, or cold sores?	☐ Yes	☐ No
9.	In the past 3 months, have you taken medications that weaken your immune system such as cortisone, prednisone, other steroids, anticancer drugs, or have you had radiation treatments?	☐ Yes	☐ No
10.	Have you had a seizure disorder, brain disorder, another nervous system problem, or Guillain Barre?	☐ Yes	☐ No
11.	During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or antiviral drugs (including acyclovir, famciclovir, valacyclovir)?	☐ Yes	☐ No
12.	Do you have a history of or a risk factor for a blood clotting disorder?	☐ Yes	☐ No
13.	Have you received any vaccinations or a TB skin test in the past 4 weeks? If so, please list: _____	☐ Yes	☐ No
14.	I acknowledge / consent to the administration of the vaccine by a pharmacy intern.	☐ Yes	☐ No
(15.)	For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐ Yes	☐ No

Consent

I certify that I am: (a) the patient and at least 18 years of age or (b) the parent or legal gaurdian of the patient. Further, I hereby give my consent to the healthcare provider of Kaup Pharmacy, Inc., to administer the vaccine(s) I have requested above. I understand the risks and benefits associated with the above vaccine(s) and have received, read and/or had explained to me the vaccine Information statements on the vaccine(s) I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. On behalf of myself, my heirs and personal represenatives, I hereby release and hold harmless the applicable Kaup Pharmacy, Inc., its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors, and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with or in any way related to the administration of the vaccine(s) listed below. I acknowledge that I understand the purpose/benefits of my state's immunization registry ("State Registry") and that Kaup Pharmacy, Inc.may disclose my immunization information to the State Registry. I acknowledge that I may prevent the disclosure of my immunization information by Kaup Pharmacy, Inc. to the State Registry by using the opt-out form. Kaup Pharmacy, Inc. will provdie me with an opt-out form upon request. I understand that I hereby do consent to Kaup Pharmacy, Inc. reporting my immunization to the State Registry. I understand that even if I do not consent or if I withdraw my consent, my state's law may permit certian disclosures of my immunization information as required or permitted by law. I voluntarily authorize and direct my healthcare provider at Kaup Pharmacy, Inc. to use or disclose my health information during the term of this authorization to the physician responsible for this protocol of specific health information of the people vaccinated at Kaup Pharmacy, Inc., my primary care physician, my insurance and/or state or federal registries where required, for the purpose of treatment, payment, or other healthcare operations. I further agree to be fully financially responsible for any cost sharing amounts, including copays, coinsurance, and deductibles, for the requested items and services as well as for any requested items and services not covered by my insurance benefits. I understand that any payment for which I am financially responsible may be due at the time of service. Additionally, I agree to wait near the vaccination location for approximately 15 minutes for observation by the pharmacist.

Name (print) _____ **Signature** _____ **Date** _____

Administration (Pharmacist Use Only)

(Pharmacist: Fill out product name, manufacturer, lot, and expiration, VIS date for each immunization given.)

	Vaccine	Product Name	Manufacturer	Lot	Exp Date	Dose	Site of Injection	Date of VIS	Signature of Administrator of Vaccine
☐	COVID-19 vaccine (M)		Moderna			0.5 ml	LD RD		
☐	COVID-19 vaccine (P)		Pfizer			0.3 ml	LD RD		
☐	COVID-19 vaccine (J&J)		Janssen			0.5 ml	LD RD		
☐	COVIC-19 Vaccine (M)	**BOOSTER**	Moderna			0.25ml	LD RD		