## 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

| # | Question | | |
|---|---|---|---|
| 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 internasal 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:____