Prevo Drug
363 Sunset Avenue, Asheboro, NC
Phone: (336)-625-4311
Fax: (336)-625-1966

Flu Vaccine Administration Record

Name: ______________________ **Sex:** Male or Female **Date of Birth:** ______________

Allergies: ______________________ **Phone:** __________ **Primary MD:** ______________

Screening Questions:

1. Are you sick today? Yes No
2. Are you allergic to eggs or latex? Yes No
3. Have you ever had a serious reaction after a vaccine (including fainting or dizziness)? Yes No
4. Do you have any health conditions such as: heart disease, diabetes, asthma? Yes No
   a. If yes, please list:____
5. Have you ever had a seizure or brain disorder, or other nervous system problems? Yes No
   a. If yes, please list: ____
6. Have you ever had Guillain-Barre Syndrome (condition that causes paralysis)? Yes No
7. For women: Are you pregnant or considering becoming pregnant in the next month? Yes No

Consent

I have read, or have had read to me, the information regarding the vaccine being administered. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine being administered and have received a copy of a current vaccine information sheet. I, on behalf of myself, my heirs, executors, personal representatives, agents, successors, and assigns herby agree to release, indemnify, and hold harmless Prevo 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. I certify that I am at least 18 years old and hereby give my consent to the pharmacists of Prevo Drug to administer the vaccine. If under 18 years old, signature by parent or guardian is required. I agree to wait near the vaccination location for approximately 15 minutes for observation by the pharmacist.

Name: ______________________ Signature: ______________________ Date: ______________
(Print Clearly)

Administration (pharmacist use only)							
Blue-E ID:				Other Ins ID: Person Code: Bin: Group: PCN:			
Vaccine	Product Name	Manufacturer	Lot	Exp Date	Dose	Site of Injection	Date of VIS