Vaccine Administration Record

Val-U-Med Pharmacy
159 Bent Ave
Las Animas, CO 81054
(719) 456-1691

Name: _____ Gender: _____ Date of Birth: _____

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

Phone: _____ Primary Care Physician Name and Address: _____

Allergies: _____ Medicare # (including letters): _____

Ethnicity (optional): Caucasian_____ African American_____ Hispanic_____ Asian_____ American Indian_____ Other_____

Screening Questions

1. Are you sick today?	YES	NO
2. Do you have allergies to medications, food, eggs, yeast, a vaccine component, or latex?	YES	NO
3. Have you ever had a serious reaction after receiving a vaccination, or 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
4. Have you had a severe allergic reaction to anything?	YES	NO
5. Are you pregnant or breastfeeding, or is there a chance you could become pregnant in the next 14 days?	YES	NO
7. 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
8. 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
9. Have you had a seizure or a brain or other nervous system problem or Guillain Barre?	YES	NO
10. Do you have a history of fainting, particularly with vaccines?	YES	NO
11. For Tdap and adult Td: Do you have a cut, injury, puncture or open wound that prompted you to get a tetanus shot?	YES	NO
12. For COVID: Have you been ill or recovered from a COVID infection or had antibody therapy in the last 3 months?	YES	NO
13. For COVID: Have you had a COVID vaccine before?	YES	NO

If yes, Which Vaccine (circle one)? Moderna Pfizer Johnson&Johnson
Date of last dose (if known): _____

I have received a Notice of Privacy Practice for HIPAA. I have read, or have had read to me, the EUA information for the COVID vaccine I am receiving I have been able to ask questions about the vaccine, and all my questions have been answered to my satisfaction. I understand the benefits and risks of the vaccine. I consent to the administration of the vaccine requested. I understand that the vaccination information will be shared with the state immunization database. I agree to stay in the general area for 15-30 minutes after receiving my vaccination in case any immediate reactions occur. If I experience any side effects, I am responsible for following up with my physician at my expense. On behalf of myself, my heirs, and my personal representatives, I hereby release the pharmacy that is administering the vaccine(s); the subsidiaries and affiliates of the pharmacy; the respective directors, officers, employees, and agents of the pharmacy and its subsidiaries and affiliates; and the owner and/or operator of the clinic site and its directors, officers, employees, and agents from any and all liability that might arise from this vaccination.

Name (print) _____ Signature _____ Date _____

PHARMACY USE ONLY BELOW THIS LINE

VACCINE(S): COVID-19 FLU Td Tdap PNEUMONIA SHINGRIX OTHER

_____ LD or RD
Signature of vaccine administrator Site of Injection
By signing as administrator you are confirming that contraindications and side effects have been reviewed and a current VIS was provided to the patient receiving the vaccine.

☐ CIIS ☐ Billing