



Type: \_\_\_\_\_  
Lot: \_\_\_\_\_  
Exp: \_\_\_\_\_  
NDC: \_\_\_\_\_  
Location: \_\_\_\_\_

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## VACCINE ADMINISTRATION RECORD

**Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ Medicare # (if applicable): \_\_\_\_\_  
**Home address:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_  
Telephone (home): \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_  
Primary Physician: \_\_\_\_\_ **Mother's Maiden Name:** \_\_\_\_\_  
**Race/Ethnicity (circle one):** Native American/Alaskan Asian African American White  
Pacific Islander Other

**Please indicate which of the following vaccines you have received:**

	Yes/No?	
Influenza	_____	An influenza vaccine is recommended each flu season
Shingles	_____	Adults 50 years and older should receive a dose of the shingles vaccine
Pneumonia	_____	Adults 65 years and older should receive the pneumococcal vaccine series
Tetanus	_____	Everyone should have a Tdap vaccine, as well as a Td booster every 10 yrs
Hepatitis B	_____	Children are routinely vaccinated against Hepatitis A and B, and you should receive the series if you have not already
Hepatitis A	_____	

**The following questions will help us determine which vaccines may be given in the pharmacy. Please answer these questions for the person receiving vaccine today. If any question is not clear, please consult the pharmacist.**

	Yes	No	Don't Know
1. Are you sick today?	_____	_____	_____
2. Do you have any allergies to medications, eggs, gelatin, Baker's yeast, streptomycin, neomycin, or other vaccine component? Please list below:	_____	_____	_____
3. Have you ever had a serious reaction after receiving a vaccination?	_____	_____	_____
4. Do you, any person who lives with you, or any person in your care have cancer, leukemia, AIDS, or any immune system problem?	_____	_____	_____
5. Do you, any person who lives with you, or any person in your care take cortisone, prednisone, other steroids, anticancer drugs, or x-ray treatment?	_____	_____	_____
6. During the past year have you received a transfusion of blood or plasma, or been given a medication called immune globulin?	_____	_____	_____
7. For women: Is it possible that you are pregnant or may become pregnant in the next 3 months?	_____	_____	_____

*I acknowledge that I have received the VIS statement and read the above and discussed with my pharmacist the benefits and risks of receiving the indicated vaccine. I give my consent to my pharmacist to administer the indicated vaccine.*

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
Pharmacist Signature

\_\_\_\_\_  
Date