KORU PHARMACY
NUTRITION | WELLNESS

Phone Number: 509-343-6252 Fax: 509-343-6251
1802 N Monroe St, Spokane, WA 99205

Type:	Type:
Lot:	Lot:
Exp:	Exp:
NDC:	NDC:
Location:	Location:

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:

Influenza	☐ Yes/No ☐	An influenza vaccine is recommended each flu season
Shingles	☐ Yes/No ☐	Adults 50 years and older should receive the shingles vaccine series
Pneumonia	☐ Yes/No ☐	Adults 65years and older should receive the pneumococcal vaccine series
Tetanus	☐ Yes/No ☐	Everyone should have a Tdap vaccine, as well as a Td booster every 10 yrs
Hepatitis A/ B	☐Yes/No ☐	Children are routinely vaccinated against Hepatitis A and B, and you should receive the series if you have not already
COVID-19	☐Yes/No ☐	If you have received this vaccine, how many doses have you had, if any? _____

Please answer the below questions for the person receiving the vaccine today. If you answer "**yes**" to any question it does not necessarily mean the vaccine cannot be given, it means that additional question may be asked. If any question is not clear, please consult the pharmacist

	Yes	No	Don't know
1. Are you sick today? Or have a history of COVID-19 infection within the past 3 months?	☐	☐	☐
2. Have you ever had a serious reaction (felt dizzy or fainted) after receiving a vaccination?	☐	☐	☐
3. Do you have a history of myocarditis or pericarditis?	☐	☐	☐
4. Do you have a history of Guillain-Barre syndrome (GBS)?	☐	☐	☐
5. Do you have a history of blood clotting or thrombosis with thrombocytopenia syndrome (TTS)?	☐	☐	☐
6. For women: Is it possible that you are pregnant or may become pregnant in the next 3 months?	☐	☐	☐
7. Do you, any person who lives with you, or any person in your care have cancer, leukemia, AIDS, or any immune system problem?	☐	☐	☐
8. 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?	☐	☐	☐
9. During the past year have you received a transfusion of blood, plasma, or been given a medication called immune globulin?	☐	☐	☐
10. Do you have any allergies to medications, eggs, gelatin, Baker's yeast, streptomycin, neomycin, or other vaccine components? Please list below:	☐	☐	☐

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_____