Vaccine Administration Record

HealthRidge Pharmacy
3130 US 70 HWY
Black Mountain, NC 28711-9108
Phone: (828) 669-9970 Fax: (828) 669-9980

Name: _____ Male: _____ Female: _____ Date of Birth: _____

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

Phone: _____ Allergies: _____ Race: _____

Primary Care Physician: _____ Office Phone Number: _____

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?	Yes	No
4.	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
5.	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?	Yes	No
6.	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
7.	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
8.	Have you had a seizure or a brain or other nervous system problem or Guillain Barre?	Yes	No
9.	During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or antiviral drug (including acyclovir famciclovir, valacyclovir)?	Yes	No
10.	For women: Are you pregnant or is there a chance you could become pregnant during the next month?	Yes	No
11.	Have you received any vaccinations or TB skin test in the past 4 weeks?	Yes	No
12.	Do you have a history of fainting, particularly with vaccines?	Yes	No
13.	**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

Consent

I have read, or have had read to me, the written information regarding the vaccine(s) 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(s) being administered and have received a copy of a current Vaccine Information Sheet. I certify that I am at least 18 years old and hereby give my consent to the pharmacists of HealthRidge Pharmacy to administer the vaccine(s). If under 18 years old signature by parent or guardian is required. I, on behalf of myself, my heirs, executors, personal representatives, agents, successors, and assigns hereby agree to release, indemnify, and hold harmless HealthRidge Pharmacy, 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).

I agree to wait near the vaccination location for approximately 15 minutes for observation by the pharmacist.

Name (print) _____ Signature _____ Date _____

Administration (Pharmacist Use Only)

Vaccine	Product Name	Manufacturer	Lot	Exp Date	Dose	Site of Injection	Date of VIS	Signature of administrator of vaccine
MMR	M-M-R II	Merck			0.5 ml	LTSC RTSC	2/12/2018	
Respiratory Synctial Virus	AREXVY	GSK			0.5 ml	LD RD	7/24/2023	
Recombinant Zoster	SHINGRIX	GSK			0.5 ml	LD RD	2/4/2022	
Varicella	Varivax	Merck			0.5 ml	LTSC RTSC	2/12/2018	
Influenza	Afluria Fluad	Sequiris	AU1061D 371597	5/31/24 5/22/24	0.5 ml	LD RD	8/6/2021	
Influenza (egg free)	Flucelvax	Sequiris	944467	6/26/24	0.5 ml	LD RD	8/6/2021	
Pneumococcal 20-valent Conjugate	Prevnar 20	Pfizer			0.5 ml	LD RD	5/12/2023	
Pneumococcal Polysaccharide (PPSV23)	Pneumovax 23	Merck			0.5 ml	LD RD	4/24/2015	
Tetanus, Diphtheria Toxoids & Acellular Pertussis (Tdap)	Boostrix	GSK			0.5 ml	LD RD	2/24/2015	