Vaccine Consent and Administration Record

BIG BEND PHARMACY 659 BIG BEND RD, ST.LOUIS,MO,63021. PH:636-438-5095.

Last Name: _____ First Name: _____DOB&Age: _____
Address: _____City:_____State:___Zip:_____Phone:_____
Primary Care Provider (PCP):_____PCP Phone Number:_____
PCP Address:_____City:_____State:___ Zip:_____
PCP Fax Number:_____.
Vaccine(s) requested:_____.

Screening Questions: Circle one

1. Are you sick today? (For example: a cold, fever or acute illness) **Yes No Don't Know**
2. Do you have allergies or reactions to any foods, medications, vaccines or latex? (For example: eggs, gelatin, neomycin, thimerosal, etc.)
   List_____ **Yes No Don't Know**
3. Do you take anticoagulation medication? (For example: warfarin, Coumadin or other blood thinner) **Yes No Don't Know**
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g. diabetes), anemia or other blood disorder? **Yes No Don't Know**
5. Do you have cancer, leukemia, HIV/AIDS or any other immune system problem? **Yes No Don't Know**
6. 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 Don't Know**
7. Have you had a seizure, brain, or other nervous system problem? (For example: Guillain-Barré syndrome) **Yes No Don't Know**
8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? **Yes No Don't Know**
9. For women: Are you pregnant or nursing? Could you become pregnant during the next month? **Yes No Don't Know**
10. Have you received any vaccinations in the past 4 weeks? **Yes No Don't Know**

If someone else manages health decisions on your behalf, please provide the following:
Caregiver Last Name:_____Caregiver First Name:_____
Relationship:_____ Phone Number:_____

Patient/Parent signature: _____. Date:_____
Vaccine Administration Information (for pharmacist use only):
Administration Date:_____ Vaccine:_____ Manufacturer:_____
Lot Number:_____Expiration Date:_____Route/Site: **L / R** DELTOID IM
Volume (mL):_____ VIS Version Date:_____ Date VIS Given to Pt:_____
Administering Immunizer Name and Title: **HAREESH KUMAR REDDY PALLI/PHARMACIST**
Administering Immunizer Signature :_____
Reported to SHOWMEVAX: YES / NO