Vaccine Administration Record

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

Name: _____ Gender: _____ Date of Birth: _____

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

Primary Phone: _____ Phone Type: _____ Race: _____

Notification Phone: _____

Email: _____ Medicare Number: _____

Allergies: _____ SSN: _____

Screening Questions

1.	Are you sick today?	Yes	No
2.	Do you have allergies to medications, food, a vaccine component, or latex?	Yes	No
3.	Have you ever had a serious reaction after receiving a vaccination?	Yes	No
4.	Have you had a seizure or a brain or nervous system problem?	Yes	No
5.	Have you ever been diagnosed with a heart condition (myocarditis or pericarditis) or have you had Multisystem Inflammatory Syndrome (MIS-A or MIS-C) after an infection with the virus that causes COVID-19?	Yes	No
6.	**HepB only**: Are you pregnant?	Yes	No
7.	Do you have a history of fainting, particularly with vaccines?	Yes	No
8.	Are you anxious about getting a vaccine today?	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 provide Medicare or other prescription drug insurance information for the billing of vaccination, if desired. If the pharmacy is unable to find or process the insurance information, I agree to pay the balance of the cost of the vaccine and/or adminstration fee. I agree to wait near the vaccination location for approximately 15 minutes after vaccination to ensure that no immediate adverse reaction occur.

Name (print) _____Signature_____Date_____

Pharmacy Use Only: Administration authorized by Barlett Steen, MD

Vaccine	Product Name	Manufacturer	Lot	Exp Date	Dose	Site of Injection	Date of VIS	Signature of administrator of vaccine
HepA & HepB Recombinant	TWINRIX	GSK			1 ml	LD RD	10/15/21 5/12/23	
Respiratory Syncitial Virus	AREXVY	GSK			0.5 ml	LD RD	7/24/2023	
Recombinant Zoster	SHINGRIX	GSK			0.5 ml	LD RD	2/4/2022	
Influenza	Afluria Flucelvax (egg free) Fluad (senior)	Sequiris	AW1613A 388524 388471	5/31/2025 6/17/2025 5/2/2025	0.5 ml	LD RD	8/6/2021	
Coronavirus	Spikevax	Moderna			0.5 ml	LD RD	10/19/2023	
	Comirnaty	Pfizer			0.5 ml	LD RD	10/19/2023	
Pneumococcal 20-valent Conjugate	Prevnar 20	Pfizer			0.5 ml	LD RD	5/12/2023	
Tetanus, Diphtheria Toxoids & Acellular Pertussis (Tdap)	Boostrix	GSK			0.5 ml	LD RD	2/24/2015	