Southpoint Pharmacy Vaccine Administration Record

Patient Name			Date of Birth	Gender
Address			Allergies	
City	State	Zip	Phone Number	
Race	Ethnicity	Primary Care Provider & Phone Number		
Medicare Part A & B ID (Including Letters)		Social Security Number		
Prescription Insurance Information Member ID		Rx Bin	RX PCN	RX Group

Screening Questions	Yes	No
1. Are you feeling sick today?	☐	☐
2. Do you have any allergies to medication, food (eggs), latex, or a vaccine component (gelatin, neomycin, polymyxin, yeast, polyethylene glycol, thiomersal)? Use dermal fillers? Please List _____	☐	☐
3. Have you ever experienced fainting or had an allergic reaction after receiving a vaccination?	☐	☐
4. 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?	☐	☐
5. 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 ?	☐	☐
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?	☐	☐
7. Have you had a seizure, or a brain or other nervous system problem, or Guillain-Barre?	☐	☐
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? In the past 90 days, have you received passive antibody therapy?	☐	☐
9. Do you have a bleeding disorder, history of or a risk factor for a blood clotting disorder? Are you taking a blood thinner?	☐	☐
10. Has any physician or other healthcare professional ever cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a physician's office or hospital?	☐	☐
11. For Women, are you pregnant or breastfeeding?	☐	☐
12. For Tdap/Td: Do you have an open wound, puncture or tissue tear that prompted you to get a tetanus shot?	☐	☐

Vaccines Needed (Check all that apply-circle option where applicable)

☐ Hepatitis A	☐ Hepatitis B	☐ Hepatitis A & B	☐ Influenza	☐ Covid-19	☐ Herpes Zoster (Shingles)
☐ Pneumococcal (20, PCV21 or 23)	☐ RSV	☐ Tetanus Diphtheria & Pertussis	☐ Human Papillomavirus	☐ Meningococcal (ACWY or B)	☐ Other_____

☐ I understand the benefits and risks of the vaccine as described in the (EUA/VIS), a copy of which I was provided with this consent form. I have had a chance to ask questions that were answered to my satisfaction. I request the vaccine to be given to me or to the person named above, a minor for whom I represent that I am authorized to sign this consent form.

☐ I agree to stay in the vaccine administration area for fifteen(15) minutes or longer if indicated by the vaccine administrator after receiving my vaccine(s) to ensure that no immediate adverse reactions occur.

Patient/Guardian Signatures_____ Date_____

******* **PHARMACY STAFF USE ONLY:**

Vaccine Given	Route	Dose	Manufacturer	Lot #	Exp Date	Date of VIS
	☐ LD ☐ RD					
	☐ LD ☐ RD					

Name & Title of Vaccine Administrator _____Date Vaccine & VIS Given