(v. 9-2023)

VACCINE ADMINISTRATION RECORD

Patient Name: _____ ☐ Male ☐ Female **Date of Birth**: _____

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

Phone: _____ **Allergies**: _____

INSURANCE: BIN: _____ PCN: _____ ID: _____ Group: _____

SCREENING QUESTIONS

Please answer the following questions by checking either **YES** or **NO**:	YES	NO
1. Are you sick today?		
2. Do you have allergies to medications, food, eggs, yeast, a vaccine component, or latex?		
3. Have you ever had a serious reaction after receiving a vaccine?		
4. Has any physician or healthcare professional ever cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a medical setting?		
5. Do you have a long-term health problem such as heart disease, lung disease, liver disease, asthma, kidney disease, metabolic disease (ex. diabetes), anemia or other blood disorder?		
6. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?		
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 had radiation treatment?		
8. Have you had a seizure, brain, other nervous system problem, or Guillain Barre?		
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 or valacyclovir)?		
10. **FOR WOMEN**: Are you pregnant or is there a chance you could become pregnant in the next month?		
11. Have you received any vaccinations or TB skin test in the past 4 weeks?		
12. Do you have a history of fainting, particularly with vaccines?		

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, on behalf of myself, my heirs, executors, personal representatives, agents, successors, and assigns hereby agree to release, indemnify, and hold harmless **Rann 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 certify that I am at least 18 years old and hereby give my consent to the pharmacists of **Rann Pharmacy** to administer the vaccine(s). If under 18 years old signature by parent or guardian is required. I agree to wait near the vaccination location for approximately 15 minutes for observation by the pharmacist, if required.

RANN PHARMACY

Name (print): _____ **Signature:** _____ **Date:** _____

	Vaccine	Manufacturer	LOT	EXP Date	Dose	Site	Date of VIS	Administrator Signature (RPh)
	Flucelvax	Seqirus			0.5ml	☐ RD ☐ LD	8/6/21	
	FluAD (65+)	Seqirus			0.5ml	☐ RD ☐ LD	8/6/21	