Appointment Date/Time: _____

VACCINE ADMINISTRATION RECORD

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

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

Phone: _____ **Allergies**: _____

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

PRIMARY PHYSICIAN INFORMATION: Name: _____ Phone: (____)_____

REQUESTED VACCINE(S):

❑ **Influenza** (injectable) ❑ RSV (Respiratory Syncytial Virus) ❑ Pneumococcal (Pneumonia) ❑ **Covid-19**
❑ Tdap (Tetanus) ❑ Zoster (Shingles): **Dose #___** ❑ Other: _____

SCREENING QUESTIONS

Please answer the following questions by checking either **YES** or **NO**:	**YES**	**NO**
1. Are you feeling sick or experiencing a moderate to high fever today? Explain: _____		
2. Have you ever had a serious reaction to any vaccinations, including fainting and feeling dizzy?		
3. Do you have any allergies to medications, food (i.e. eggs), latex, vaccine component (e.g. neomycin, formaldehyde, gentamicin, thimerosal, bovine protein, polymyxin, gelatin, phenol, or yeast? If yes, please circle.		
4. Do you have a long-term health problem with heart, lung, kidney, metabolic disease (eg.diabetes), asthma, blood disorder, no spleen, complement component deficiency, cochlear implant, spinal fluid leak, or long-term aspirin?		
5. **FOR WOMEN**: Are you pregnant or considering becoming pregnant in the next month?		
6. **FOR Tdap (tetnus)**: Do you have an open wound, puncture or tissue tear that prompted this vaccine?		
7. Do you have a parent, brother, or sister with an immune system problem? Explain: _____		
8. Have you had any vaccinations or skin test within the past **4 weeks**? Please list: _____		
9. Do you have cancer, leukemia, HIV/AIDS, or any other condition that weakens the immune system?		
10. During the past year, have you received transfusions of blood or blood products, or had immune globulin?		
11. In the past **3 months**, have you taken medications that affect your immune system, such as prednisone, steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's, or psoriasis; or had radiation?		
12. Have you had a seizure or a brain or other nervous system problem?		

CONSENT

I certify that I am: (a) the patient and at least 18 years of age or (b) the parent or legal guardian of the patient. Further, I hereby give my consent to the healthcare provider of **RANN PHARMACY** to administer the vaccine(s) I have requested. I understand the risks and benefits associated with the above vaccine(s) and have received, read and/or had explained to me the Vaccine Information Statement (s) on the vaccine(s) I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. Additionally, it is recommended to wait for 15 minutes following the vaccination before leaving the premises. On behalf of myself, my heirs, and personal representatives, I hereby release and hold harmless Rann ı harmacy, its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine(s) requested. I acknowledge that I understand the purpose/benefits of my state s immuni_ation registry ("State Registry) and the ı rovider may disclose my immuni_ation information to the State Registry. I acknowledge that, depending upon my state s law, I may prevent the disclosure of my immuni_ation information by the applicable ı rovider to the State Registry by using the opt out form. Rann ı harmacy will, if my state permits, provide me with an Opt Out Form. I understand that, depending on my state s law, I may need to specifically consent, and to the extent required by my state s law, by signing below, I hereby do consent to the ı rovider reporting my immuni_ation information to the State Registry. I understand that even if I do not consent or if I withdraw my consent, my state s laws may permit certain disclosures of my immuni_ation information as required or permitted by law. I voluntarily authori_e and direct my healthcare provider at **RANN PHARMACY** to use or disclose my health information during the term of this Authori_ation to the physician responsible for this protocol of specific health information of people vaccinated at Rann ı harmacy, my ı rimary Care ı hysician, my insurance and/or state or federal registries, where required, for the purpose of treatment, payment or other healthcare operations, I further agree to be fully financially responsible for any cost sharing amounts, including copays, coinsurance and deductibles, for the requested items and services as well as for any requested items and services not covered by my insurance benefits. I understand that any payment for which I am financially responsible is due at the time of service.

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

Vaccine Rx Backtag

Vaccine Rx Backtag

Have you had the following vaccines:		
13. Pneumococcal Vaccine (Prevnar 15 or 20)		
14. Shingles Vaccine (Shingrix)		
15. Tdap (Whooping Cough, Tetanus) Vaccine		

FOR PHARMACY USE ONLY:

	Vaccine	NDC	Manufacturer	Dose (ml)	VIS Date	LOT	EXP Date	Site of Admin	Route of Admin
	Influenza	Flucelvax	*Seqirus*	0.5	08/06/21		06/24	❑ RA ❑ LA	❑ IM
	Influenza (65+)	FluAD+	*Seqirus*	0.5	08/06/21		06/24	❑ RA ❑ LA	❑ IM
	Zoster (Singles)	Shingrix	*GSK*	0.5	02/04/22			❑ RA ❑ LA	❑ IM
	Pneumococcal (Pneumonia)	Prevnar-20	*Pfizer*	0.5	05/12/23			❑ RA ❑ LA	❑ IM
	Tdap (Tetanus, Whooping Cough)	Boostrix	*GSK*	0.5	08/06/21			❑ RA ❑ LA	❑ IM
	RSV	Abrysvo	*Pfizer*	0.5	07/24/23			❑ RA ❑ LA	❑ IM
	Covid-19	❑ Comirnaty ❑ Spikevax	❑ *Pfizer* ❑ *Moderna*	0.3 0.5	09/11/23			❑ RA ❑ LA	❑ IM
	Other: _____							❑ RA ❑ LA	❑ IM ❑ SQ

Administered by (Signature): _____

Administered by (Printed) : _____

Supervising Pharmacist Signature (if applicable): _____

Date VIS Given to Patient: _____

(v. 10-2023)