

### Vaccine Administration Record-Informed Consent for Vaccination

Name: \_\_\_\_\_ Gender: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Race:  American Indian  Asian  Black or African American  Native Hawaiian or Other Pacific Islander  
 White  Other: \_\_\_\_\_  Unknown

Ethnicity:  Hispanic  Non-Hispanic  Unknown

#### The following questions will help us determine your eligibility to be vaccinated today

- |  |     |    |
|--|-----|----|
| 1. Are you sick today?   | Yes | No |
| 2. <b>If receiving COVID vaccine:</b> Have you previously received a dose of the COVID-19 vaccine?<br>Last date received: _____ Doses Received: 1 2 3 4  | Yes | No |
| 3. In the past 14 days have you had contact with a confirmed COVID-19 patient?   | Yes | No |
| 4. Do you have any allergies to medications, food, eggs, yeast, vaccine components or latex?<br>If yes, list here: _____   | Yes | No |
| 5. Have you ever had a serious allergic reaction after receiving a vaccine (including a previous dose of the COVID-19 vaccine)?  | Yes | No |
| 6. Has any physician or other healthcare professional ever cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a medical setting?                            | Yes | No |
| 7. 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?          | Yes | No |
| 8. 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, herpes, or cold sores?  | Yes | No |
| 9. 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 |
| 10. Have you had a seizure or a brain or other nervous system problem or Guillain Barre?   | Yes | No |
| 11. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug (including acyclovir, famciclovir, valacyclovir)? | Yes | No |
| 12. <b>For women:</b> Are you pregnant or is there a chance you could become pregnant during the next month?   | Yes | No |
| 13. Have you received any vaccinations or a TB skin test in the past 4 weeks?  | Yes | No |
| 14. Do you have a history of fainting, particularly with vaccines?   | Yes | No |
| 15. <b>For Tdap and adult Td:</b> Do you have a cut, injury, puncture or open wound that prompted you to get a tetanus shot?   | Yes | No |
| 16. <b>For Zoster:</b> Have you had a past reaction to gelatin or triple antibiotic ointment?  | Yes | No |

#### Insurance Information

ID number:	Cardholder if not you:	RxPCN:
RxBIN:	RxGroup:	Last 4 of SSN:

I have read, or have had read to me, the written information regarding the vaccine(s) marked above. 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 for each vaccine I am receiving today. I, on behalf of myself, my heirs, executors, and personal representatives, agents, successors, and assigns hereby agree to release, indemnify, and hold harmless Uptown 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) marked above. I certify that I am at least 18 years old and hereby give my consent to Uptown Pharmacy to administer the vaccines marked above. 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.

Patient/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

#### THIS SECTION IS FOR HEALTHCARE PROVIDER ONLY

Vaccine/Manufacturer	Vaccine Lot #	Exp Date:	Dosage	Deltoid:	Date of VIS	Dose #
				L or R		
				L or R		

Administered By: \_\_\_\_\_ Date: \_\_\_\_\_

Supervising Pharmacist: \_\_\_\_\_ Signature: \_\_\_\_\_