Patient Name (Last, First)	DOB	
Address	Phone	
City	State	Zip
Social Security #	Gender Male □ Female □	

PAW PAW VILLAGE PHARMACY

Vaccine Administration Record

Section 2: Screening Questions

1. Are you sick today?	□ Yes	□ No	□ Unknown
2. Do you have allergies to medications, food, latex or a vaccine component? **(If yes please list here):**	□ Yes	□ No	□ Unknown
3. Have you had any serious reactions to vaccines in the past? **(If yes please list here):**	□ Yes	□ No	□ Unknown
4. Do you have a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Are you on long-term aspirin therapy?	□ Yes	□ No	□ Unknown
5. For women: Are you pregnant or is there a chance you could become pregnant in the next month?	□ Yes	□ No	□ Unknown
6. During the past year, have you received a transfusion of blood or blood products or been given immune (gamma) globulin or an antiviral drug?	□ Yes	□ No	□ Unknown
7. In the past 3 months have you taken medications that affect your immune system such as prednisone, steroids, or other drugs for rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?	□ Yes	□ No	□ Unknown
8. Have you received any vaccinations in the past 4 weeks? **(If yes, please list date received here):**	□ Yes	□ No	□ Unknown
9. Has the person to be vaccinated ever had Guillain-Barré syndrome?	□ Yes	□ No	□ Unknown

Patient Name: _____Patient Signature: _____Date: _____

Section 4: Vaccine Information (Pharmacy Use Only)

Vaccine	Manufacturer	NDC	Dose	Lot Number	Exp. Date	Site of Admin.	Route of Admin
1.						□ L Arm □ R Arm □ L Thigh □ R Thigh	□ IM □ SubQ □ Nasal □ Oral
2.						□ L Arm □ R Arm □ L Thigh □ R Thigh	□ IM □ SubQ □ Nasal □ Oral

Pharmacist/Healthcare Provider Signature:_____

Administration Date and VIS Given: _____

Section 3: Consent For Vaccination

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 Paw Paw Village Pharmacy (PPVP) to administer the vaccine(s) listed below. I understand the risks and benefits associated with the below vaccine(s) and have received, read, and/or had explained to me the Vaccine Information Statements (VIS) 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. On behalf of myself, my heirs, and personal representatives, I hereby release and hold harmless the applicable Provider, 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) listed below. I acknowledge that I understand the purposes/benefits of my state's immunization registry ("State Registry") and the Provider may disclose my immunization information to the State Registry. I acknowledge that, depending upon my state's law, I may prevent the disclosure of my immunization information by the applicable Provider to the State Registry by using the opt-out form. The Provider 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 Provider reporting my immunization 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 immunization information as required or permitted by law. I voluntarily authorize and direct my healthcare provider at PPVP to use or disclose my health information during the term of this Authorization to the physician responsible for this protocol of specific health information of people vaccinated at PPVP, my Primary Care Physician, 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.