VACCINE ADMINISTRATION RECORD

Name_____ Male____ Female____ Date of Birth_____

Address_____ City_____ State_____ Zip_____

Phone: (___)_____ Social Security # _____-_____-_____ Medicare # (including letters)_____

Allergies_____ Primary Care Physician and Phone Number: _____

Ethnicity (optional): Caucasian African-American Hispanic Asian American Indian Other - _____

Screening Questions

1.	Are you sick today?	YES	NO
2.	Do you have allergies to medications, food, eggs, yeast, a vaccine component, or latex?	YES	NO
3.	Have you ever had a serious reaction after receiving a vaccination?	YES	NO
4.	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
5.	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
6.	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
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 have you had radiation treatments?	YES	NO
8.	Have you had a seizure or a brain or other nervous system problem or Guillain Barre?	YES	NO
9.	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
10.	**For women:** Are you pregnant or is there a chance you could become pregnant during the next month?	YES	NO
11.	Have you received any vaccinations or TB skin test in the past 4 weeks?	YES	NO
12.	Do you have a history of fainting, particularly with vaccines?	YES	NO
13.	**For Tdap and adult Td:** Do you have a cut, injury, puncture or open wound that prompted you to get a tetanus shot?	YES	NO
14.	**For Zoster:** Have you had a past reaction to gelatin or triple antibiotic ointment?	YES	NO

MEDICARE RECIPIENTS PLEASE COMPLETE THE SECTION BELOW:
Please check one:

☐ *I hereby authorize _____ (pharmacy) to bill Medicare Part B/Part D on my behalf. I request that payment of authorized Medicare benefits be made to _____ (pharmacy) for the above vaccine and its administration as furnished to me by _____ (pharmacy). I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits payable for related services.* **Medicare Health Insurance Claim Number (HICN):** _____

☐ *I hereby attest that as of the date indicated above, I am not enrolled in Medicare Part B/Part D.*

PRIVATE INSURANCE HOLDERS PLEASE COMPLETE THE SECTION BELOW:
Please check one:

☐ *I hereby authorize _____ (pharmacy) to bill _____ (insurance) on my behalf. I request that payment of authorized benefits be made to _____ (pharmacy) for the above vaccine and its administration as furnished to me by _____ (pharmacy). I authorize any holder of medical information about me to release to _____ (insurance) and its agents any information needed to determine these benefits payable for related services.*

Subscriber ID #: _____ **Group #:** _____ **BIN #:** _____

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, personal representatives, agents, successors, and assigns hereby agree to release, indemnify, and hold harmless Mutual Drug, 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 the pharmacists of this Mutual Member Drug Store to administer the vaccine(s) marked above. If under 18 years old signature by parent or guardian required. **I AGREE TO WAIT NEAR THE VACCINATION LOCATION FOR APPROXIMATELY 15 MINUTES FOR OBSERVATION BY A MUTUAL DRUG MEMBER PHARMACIST.**

Name (print) _____ Signature _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

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

Vaccine to be administered: _____ Influenza _____ Pneumococcal Polysaccharide _____ Pneumococcal Conjugate _____Herpes Zoster
_____ Hepatitis B _____ Meningococcal Polysaccharide _____ Meningococcal Conjugate _____ Tetanus-Diphtheria
_____ Tetanus and Diphtheria Toxoids and Pertussis _____ Tetanus and Diphtheria Toxoids and Acellular Pertussis _____ Tetanus Toxoid

1. _____ _____ _____
Vaccine name & manufacturer Lot# & exp. date Dose

LD or RD _____ _____
Site of Injection Date of VIS Signature of administrator of vaccine

2. _____ _____ _____
Vaccine name & manufacturer Lot# & exp. date Dose

LD or RD _____ _____
Site of Injection Date of VIS Signature of administrator of vaccine

Store Stamp:

Primary Care MD notified: Date:_____
Phone____ Fax____ RPh/Tech:_____

Scanned with CamScanner