Vaccine Administration Record

Boalsburg Apothecary
3901 S Atherton St
State College, PA 16801-8324
Phone: (814) 466-7936 Fax: (814) 466-7825

Name: ______________________ Male: _________ Female: _________ Date of Birth: ___________________

Address: ______________________ City: ______________________ State: ____________ Zip: ____________

Phone: ________________ Allergies: ______________________

Screening Questions

1. Are you sick today? Yes No
2. Do you have allergies to medications, food, latex or a component of the vaccine? Yes No
3. Have you ever had a serious reaction, including anaphylaxis 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. For women: Are you pregnant or is there a chance you could become pregnant during the next month? Yes No
10. Do you have a history of fainting, particularly with vaccines? Yes No
11. Have you received any other vaccines within the last 2 weeks? If yes, please indicate which vaccine Yes No

If yes, please provide vaccine name:______________________

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 Boalsburg Apothecary, 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 Boalsburg Apothecary 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.

Name (print) ______________________ **Signature** ______________________ **Date** ______________

Administration (Pharmacist Use Only)

Vaccine	Product Name	Manufacturer	Lot	Exp Date	Dose	Site of Injection	Date of VIS	Signature of Administrator of Vaccine
						LD RD		