Vaccine Administration Record

Patient information: (Patient to complete) Today's Date: _____

Name:_____ Gender: Male / Female Phone:_____

Birth Date:_____ Age:_____

Address:_____

City:_____ State:_____ ZIP:_____

Medicare Part A & B ID # (red/white/blue card) _____

Primary Care Physician:_____

Vaccine you would like to receive today?_____

PHARMACY USE ONLY

Vaccine:

Lot #:_____
Exp Date:_____
Site: RA or LA

Vaccine Administrator: Seth Moe, PharmD, or Stevie Wessel, PharmD

_____Title: Registered Pharmacist _____
Signature of Administrator Date

Three Lakes Pharmacy
PO Box 437
1790 Superior St, Three Lakes, WI 54562
www.threelakespharmacy.com

VIS_____

The following questions will help us determine which vaccines may be given today. If a question is unclear, please ask your pharmacist to explain.	**Yes**	**No**	DON'T KNOW
Are you currently ill or do you have a fever?			
Do you have a long term health problem with heart disease, kidney disease, metabolic disorder (eg. diabetes), anemia or other blood disorders?			
Do you have a long term health problems with lung disease or asthma? Do you smoke?			
Do you have an allergies to medication, food (i.e. eggs), latex, or any vaccine component (e.g. neomycin, gentamicin, thimerosal, bovine protein, phenol, formaldehyde, polymyxin, gelatin, bakers yeast or yeast)?			
Have you received any vaccination in the past 4 weeks?			
Have you had a serious reaction after receiving a vaccination?			
Do you have a neurological disorder such as seizures or other disorders that affect the brain or have had a disorder that resulted from a vaccine (e.g. Guillain-Barre Syndrome)?			
Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have had radiation treatments?			
Do you have a blood-clotting disorder, take blood-thinning medications, or have received blood transfusions during the past year?			
Are you a parent, family member, or caregiver to a new born infant?			
For women: Are you pregnant or could you become pregnant in the next three months?			
Have you had the following vaccine:	**Yes**	**No**	**Don't Know**
• Pneumonia Vaccine (Pneumovax23 recommended for 65+)			
• Shingles Vaccine (1st and 2nd doses of Shingrix for 50+)			
• Whooping Cough (Tdap) Vaccine			

I authorize the pharmacist to send copies of my vaccine documents to my primary care provider. Failure to select one of these boxes will result in the vaccine documents to be sent to provider if known.

Yes- ☐ No- ☐

I have read, or have had explained to me, the CDC Vaccine Information Statement regarding the vaccine(s). I understand the risk and benefits associated with the vaccine. I have had an opportunity to ask questions which were answered to my satisfaction. I understand the benefits and risks of vaccine and request that the vaccine be given to me (or person named previous for whom I am authorized to make this request). I acknowledge that the pharmacist recommends that vaccinated patients should remain in the waiting area for 20 minutes after the administration of the vaccine. I acknowledge that if my insurance does not cover the cost of administering the vaccine at the pharmacy, I am responsible for payment by signing this form.

_____ _____

Signature Date