

# Vaccine Administration Record

U-Save Pharmacy  
3611 2nd Ave  
Kearney, NE 68847-8104  
Phone: (308) 455-1555 Fax: (308) 708-2699

Name: \_\_\_\_\_ Male: \_\_\_\_\_ Female: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Allergies: \_\_\_\_\_ Race: \_\_\_\_\_  
 Primary Care Physician: \_\_\_\_\_ Office Phone Number: \_\_\_\_\_

## 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 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 |

## 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 U-Save 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). I certify that I am at least 18 years old and hereby give my consent to the pharmacists of U-Save Pharmacy 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
Influenza (TIV)	Flutaval	GSK			.5 ml	LD RD	8/7/2015	
Pneumococcal Polysaccharide (PPSV23)	Pneumovax 23	Merck			.5 ml	LD RD	4/24/2015	
Pneumococcal Conjugate (PCV13)					.5 ml	LD RD	11/5/2015	
Herpes Zoster	Shingrix	GSK			.5 ml	LD RD	2/12/2018	
Hepatitis B (Age 20+)	Engerix - B (Adult)	GSK			1 ml	LD RD	7/20/2016	
Meningococcal Conjugate (MCV4)					.5 ml	LD RD	3/31/2016	
Meningococcal Polysaccharide (MPSV4)					.5 ml	LD RD	3/31/2016	
Tetanus-Diphtheria (Td)	Tenivac	Sanofi			.5 ml	LD RD	4/11/2017	
Tetanus, Diphtheria Toxoids & Acellular Pertussis (Tdap)	Boostrix	GSK			.5 ml	LD RD	2/24/2015	

