

**COVID / RSV / INFLUENZA / PNEUMONIA / Tdap / SHINGLES / MPox / Hep. B
Vaccine Administration Record**

Name: _____ Date of Birth: _____ Male: ___ Female: ___
 Address: _____ City: _____ State: _____ Zip: _____
 Phone: _____ Race: _____ Ethnicity: _____ Mother's Maiden Name: _____

I would like to get the following vaccines today (circle all that apply):

COVID
 RSV
 INFLUENZA
 PNEUMONIA
 SHINGLES
 Tdap
 MPox
 HEP. B

For vaccine recipients (both children and adults):

The following questions will help us determine if there is any reason your vaccines cannot be given today. **If you answer "yes" to any question, it does not necessarily mean the vaccine cannot be given.** It just means additional questions may be asked. If a question is not clear, please ask the pharmacist to explain it.

				DON'T							DON'T		
				YES	NO	KNOW					YES	NO	KNOW
1.	Are you sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5.	Have you had a seizure or a brain or other nervous system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
2.	Do you have allergic reactions to medications, food, a vaccine component, or latex? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6.	In the past 6 months, have you taken medications that affect your immune system (prednisone, steroids, anticancer drugs, drugs for arthritis or radiation treatments)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
3.	Have you ever had serious reactions to this vaccine or any other vaccine that resulted in hives, swelling, wheezing, etc. or caused you to go to the hospital? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7.	In the past year, have you received immune globulin, blood/blood products, or an antiviral drug?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
4.	Do you have any of the following: long-term health problems with heart, lung, kidney, metabolic disease, asthma, blood disorder, cochlear implant, cancer, HIV, or undergoing treatment that makes you moderately or severely immunocompromised?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8.	Have you received the COVID-19 vaccine before or during hematopoietic cell transplant (HCT) or CAR-T-cell therapies?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
					9.	How old is the person to be vaccinated? _____							
10.	Check all that apply: <input type="checkbox"/> History of myocarditis/pericarditis <input type="checkbox"/> History of Multisystem Inflammatory Syndrome (MIS-C/MIS-A)? <input type="checkbox"/> History of immune-mediated syndrome defined by thrombosis and thrombocytopenia <input type="checkbox"/> History of Guillain-Barre Syndrome (GBS) <input type="checkbox"/> Have an immediate relative with an immune system problem				Check all that apply: <input type="checkbox"/> History of COVID-19 disease within the past 3 months <input type="checkbox"/> You were vaccinated with any vaccine in the last 4 weeks <input type="checkbox"/> You may be pregnant <input type="checkbox"/> You are taking aspirin long-term <input type="checkbox"/> You have felt dizzy or faint before, during or after a shot								

CONSENT AND AUTHORIZATION:

I have been offered and had a chance to read the Vaccine Information Sheet (VIS) for the vaccine(s) I will be receiving today and have been able to ask questions about the vaccine(s) I am receiving. I understand the benefits and risks of the vaccine and request that the vaccine be given to me or to the person for whom I am authorized to make this request. I acknowledge that any reaction to multiple vaccines in a day may make it difficult to understand which vaccine caused the reaction. I understand that all information will be kept confidential and protected under HIPAA and agree to remain under observation for at least 10 minutes after receiving my vaccine at the pharmacy. I authorize River Oak Pharmacy to bill my insurance if I am covered and understand I am responsible for all charges not covered by my insurance. I also understand my immunization information will be entered into the RIDE/Healthy Futures Immunization Registry. I release River Oak Pharmacy from all claims relating directly or indirectly to the administration of the vaccine to my self or to the person or whom I am signing. I further agree to indemnify and hold River Oak Pharmacy harmless from all claims. I, the undersigned, certify that all the above information is true and correct to the best of my knowledge.

Patient/POA/Legal Guardian PRINT _____ SIGN _____ Date: _____

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