- Medicaid or Medicare ID#_____
- Private Insurance
- Cash

- Influenza
- Tetanus (Tdap)
- Pneumonia
- Shingles (Zoster)

Vaccine Administration Record & Consent Form

Patient Name	**Date of Birth**	**Age**	**Phone Number**

Street Address	**City**	**State**	**Zip Code**

Primary Care Doctor	**Doctor's Phone Number**

Allergies:

Questionnaire (All Vaccines)	**Yes**	**No**
1. Are you sick today?		
2. Do you have allergies to medications, food, yeast, a vaccine component (**neomycin** or **latex**)?		
3. Have you ever had a serious reaction after receiving a vaccination?		
4. Has any doctor or other healthcare professional every cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a medical setting?		
5. Do you have any long-term health problems (heart disease, lung disease, liver disease, diabetes etc.)?		
6. Do you have cancer, leukemia, HIV/AIDS or any other immune problem?		
7. Have you taken any medication that could weaken your immune system in the **last 3 months**? (prednisone, cortisone, other steroids or anticancer drugs, or radiation)		
8. Have you had a seizure or a brain or nervous system problem or Guillain Barre?		
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?		
10. Have you received any vaccinations or TB skin test in the past **4 weeks**?		
11. Do you have a history of fainting, particularly with vaccines?		
For Zoster Only (Shingles Vaccine)		
Have you ever had a past reaction with gelatin?		
For Tetanus Vaccine Only		
Do you have a cut, injury, puncture or open wound that prompted you to get a tetanus shot? (If "yes" you must seek proper medical attention and **cannot** receive the vaccine from the pharmacy.)		
For Women Only		
Are you pregnant or is there a chance you will become pregnant in the next year?		

I have been offered a copy of the Vaccine Information Statement(s) (VIS) on the vaccine(s). I have read, had explained to me, and understand the information in the VIS(s). I am aware of the benefits and risks of the vaccination(s) about to be given, and I ask that the vaccine(s) **requested above** to be given to me or to the person named above for who I am authorized to make this request. I fully release and discharge Cape Fear Discount Drug (CFDD) as well as it's employees of any liability related to illness, injury, loss or damage related to the vaccine administration. Additionally, I authorize CFDD to accept payment on my behalf from my insurance company (including **Medicaid** or **Medicare**) for the cost of the vaccine and any applicable administration fees, as well as release medical records to health care providers or third party payers as it relates to this vaccine.

Signature of Patient or Parent/Guardian **Date**

Pharmacy Use Only	
(PLACE RX LABEL HERE)	**(PLACE RX LABEL HERE)**

Lot #	**Lot #**
Expiration:	**Expiration:**
Site: LA / RA	**Site: LA / RA**
Route: IM / SQ	**Route: IM / SQ**
VIS Date:	**VIS Date:**

Vaccinating Pharmacist's Signature_____

License # _____

Date_____