Vaccine Administration Record

1.	**Are you sick today?**	**YES**	**NO**
2.	**Are you pregnant or is there a chance you could become pregnant during the next month?**	**YES**	**NO**
3.	**Do you have any allergies to medications, foods (ex. Eggs), latex, or a vaccine component (gelatin, neomycin, polymyxin, yeast, etc)?**	**YES**	**NO**
4.	**Do you have a long term health problem such as asthma, diabetes, anemia, heart, lung, liver, or kidney disease?**	**YES**	**NO**
5.	**Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem (rheumatoid arthritis, ankylosing spondylitis, or Crohn's disease)?**	**YES**	**NO**
6.	**In the past 3 months, have you taken medications that weaken your immune system (ex Cortisone, prednisone, other steroids, or anti-cancer drugs? Have you had radiation treatments?**	**YES**	**NO**
7.	**Have you received any vaccines within the past 4 weeks?**	**YES**	**NO**
8.	**In the past year, have you received blood products, immune globulin, or an antiviral drug?**	**YES**	**NO**
9.	**Have you ever had a serious reaction (including fainting) after receiving a vaccination?**	**YES**	**NO**
10.	**Are you anxious about getting a shot today?**	**YES**	**NO**
11.	**Have you had a seizure, or a brain or other nervous system problem, or Guillain-Barre syndrome?**	**YES**	**NO**

I have read, or have had read to me, the written information above and have had an opportunity to ask questions. I understand the benefits and risks of the vaccine as described. I, on behalf of myself, my heirs, executors, personal representatives, agents, successors, and assigns hereby agree to release, indemnify, and hold harmless Stokes 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) marked below. I certify that I am at least 18 years old and hereby give my consent to the pharmacists of Stokes Pharmacy to administer the vaccine(s) to me or the person named below for whom I am authorized to sign. **I AGREE TO WAIT NEAR THE VACCINATION LOCATION FOR AT LEAST 15 MINUTES FOR OBSERVATION BY A STOKES PHARMACY EMPLOYEE.**

First and Last Name	**Date of Birth**	**Age**	**Gender (M/F)**
Street Address	**City, State, Zip**		
Phone #	**Drug/Food Allergies**	**Physician's Name**	
Signature of Person Receiving Vaccine		**Today's Date**	

To be completed by immunizing pharmacist:

Vaccine Name: _____

Injection Site: L / R deltoid

Vaccine Manufacturer: _____ Lot #: _____ Exp. Date: _____

Signature of Vaccine Administrator: _____ Date: _____

BSP
BROAD STREET PHARMACY

STOKES PHARMACY