WALBERG FAMILY PHARMACIES VACCINE ADMINISTRATION REPORT

NAME:____ DOB: _______________________

ADDRESS:____ SEX:________________________

CITY:________________________ STATE:________ ZIP:_________________

PHONE:____

EMAIL:____

ALLERGIES:____ PCP:________________________

Screening Checklist for Influenza Vaccine

PATIENT QUESTIONS-ANSWER THE DAY OF THE VACCINATION		
Are you sick today	□YES	□NO
Do you have allergies to any medications, food, or vaccines? Examples: eggs, yeast, neomycin, gelatin, polymyxin, gentamicin, bovine protein, phenol, or thimerosal	□YES	□NO
Have you ever had a severe allergic reaction (e.g. anaphylaxis) in the past? Have you ever used an Epi-Pen due to an allergic reaction?	□YES	□NO
Have you ever had a serious reaction after a vaccination?	□YES	□NO
Have you received a vaccine in the past 14 days?	□YES	□NO
Have you had a seizure, brain or nerve problem, or Guillain-Barre Syndrome?	□YES	□NO
Do you have a bleeding disorder or are you taking a blood thinner?	□YES	□NO
For women, are you currently pregnant or breastfeeding?	□YES	□NO
If patient is under 18 years of age, parent or legal guardian must be present. Patient must follow up with his/her primary care physician for annual well visit.		

Insurance Information:

Rx BIN_______________________________________

ID ____

Group____

PCN ____

MEDICARE ID OR SSN___________________________

SIGNATURE/LEGAL GUARDIAN:___________________________ DATE:_________

NAME (PRINT):____ PHARMACIST'S SIGNATURE_____________________________

Consent for Services, Medical Records, and HIPAA Privacy Information 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 voluntarily assume full responsibility for any reactions that may result. I, on behalf of myself, my heirs, executors, personal representatives, agents, successors, and assigns hereby agree to release, indemnify, and hold harmless Walberg Family Pharmacies 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 this Walberg Family Pharmacies 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.

VACCINE ADMINITRATION INFORMATION (Immunizer/Pharmacist Use Only)

Vaccine	Manufacturer	Lot	Expiration Date	Dose & Route	Site	Date of VIS/EUA	Person receiving VIS	Date VIS received
QUADRIVALENT INFLUENZA				0.5 IM	LD RD	08/2021	Self	