Suncrest Pharmacy

Type:	Type:
Lot:	Lot:
Exp:	Exp:
NDC:	NDC:
Location:	Location:

VACCINE ADMINISTRATION RECORD

Name: _____ **DOB:** _____ Medicare # (if applicable): _____
Home address: _____ **Zip Code:** _____
Telephone (home): _____ (work) _____ (cell) _____
Primary Physician: _____ **Mother's Maiden Name:** _____
Race/Ethnicity (circle one): Native American/Alaskan Asian African American White Pacific Islander Other

Please indicate which of the following vaccines you have received:

	Yes/No?	
Influenza	_____	An influenza vaccine is recommended each flu season
Shingles	_____	Adults 50 years and older should receive a dose of the shingles vaccine
Pneumonia	_____	Adults 65 years and older should receive the pneumococcal vaccine series
Tetanus	_____	Everyone should have a Tdap vaccine, as well as a Td booster every 10 yrs
Hepatitis B	_____	Children are routinely vaccinated against Hepatitis A and B, and you should
Hepatitis A	_____	receive the series if you have not already

The following questions will help us determine which vaccines may be given in the pharmacy. Please answer these questions for the person receiving vaccine today. If any question is not clear, please consult the pharmacist.

	Yes	No	Don't Know
1. Are you sick today?	___	___	____
2. Do you have any allergies to medications, eggs, gelatin, Baker's yeast, streptomycin, neomycin, or other vaccine component? Please list below:	___	___	____
3. Have you ever had a serious reaction after receiving a vaccination?	___	___	____
4. Do you, any person who lives with you, or any person in your care have cancer, leukemia, AIDS, or any immune system problem?	___	___	____
5. Do you, any person who lives with you, or any person in your care take cortisone, prednisone, other steroids, anticancer drugs, or x-ray treatment?	___	___	____
6. During the past year have you received a transfusion of blood or plasma, or been given a medication called immune globulin?	___	___	____
7. For women: Is it possible that you are pregnant or may become pregnant in the next 3 months?	___	___	____

I acknowledge that I have received the VIS statement and read the above and discussed with my pharmacist the benefits and risks of receiving the indicated vaccine. I give my consent to my pharmacist to administer the indicated vaccine.

_____ _____
Patient Signature **Date**

_____ _____
Pharmacist Signature Date

P: 509-413-2030 F: 509-413-2091
5919 Hwy 291 Ste 5, Nine Mile Falls, WA 99026
Reference: The Centers for Disease Control and Prevention (CDC), accessed January 4, 2017