Vaccine Administration Record

ALPS Pharmacy
2650 W Kearney St
Springfield, MO 65803-2037
Phone: (417) 865-1547 Fax: (417) 862-2571

Name: _____ **Male:** __ **Female:** __ **Date of Birth:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Allergies:** _____ **Race:** _____

Primary Care Doctor: _____ **Office Phone Number:** _____

Address: _____ **Office Fax Number:** _____

SSN: _____ ***Bin:*** _____ ***PCN*** _____ ***Group:*** _____ ***Member ID*** _____

Please Provide Pharmacy with current insurance card, if possible.

Screening Questions

1. Are you sick today? (Pharmacy staff-list current temperature: _____)	Yes	No
2. Do you have allergies to medications, food, eggs, yeast, a vaccine component, or latex?	Yes	No
3. Have you ever had a serious reaction after receiving a vaccination?	Yes	No
4. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem? Have you been diagnosed with rheumatoid arthritis, ankylosing spondylitis, Crohns disease, herpes, or cold sores?	Yes	No
5. In the past 3 months, have you taken medications that weaken your immune system such as cortisone, prednisone, and/or other steroids, or anticancer drugs, or have you had radiation treatments?	Yes	No
6. Have you had a seizure or a brain or other nervous system problem or Guillain Barre?	Yes	No
7. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	Yes No	N/A
8. Have you received any vaccinations or a TB skin test in the past 4 weeks?	Yes	No

Consent

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, on behalf of myself, my heirs, executors, personal representatives, agents, successors, and assigns hereby agree to release, indemnify, and hold harmless ALPS 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). I certify that I am at least 18 years old and hereby give my consent to the pharmacists of ALPS Pharmacy 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.
I consent to my vaccination record being sent to the ShowMeVax database.
If your insurance denies payment, you will be billed for the services rendered.

Name (print): _____ **If guardian check this box:** ☐ **ShowMeVax opt out:** ☐

Signature: _____ **Date** _____

Administration (Pharmacist Use Only)

Vaccine:	Product Name:	Admin Directions:	Mfg:	Lot:	Exp:	Dose:	Inj Site:
Influenza Quad MDV	Fluzone MDV	Inject 0.5 ml IM once	Sanofi			0.5 ml	IM: LD RD
	'Afluria MDV	Inject 0.5 ml IM once	Seqirus			0.5 ml	IM: LD RD
Influenza Quad PFS	Afluria PFS	Inject 0.5 ml IM once	Seqirus			0.5 ml	IM: LD RD
Influenza Adj (>65)	Fluad	Inject 0.5 ml IM once	Seqirus			0.5 ml	IM: LD RD
Pneumococcal PPSV 23	Pneumovax 23	Inject 0.5 ml IM once	Merck			0.5 ml	IM: LD RD
Pneumococcal 20-var	Prevnar 20	Inject 0.5 ml IM once	Pfizer			0.5 ml	IM: LD RD
Herpes Zoster	Shingrix	Inject 0.5 ml IM once	GSK			0.5 ml	IM: LD RD
Hepatitis B (Recombinant)	PreHevbrio 3 Dose	1ml IM once(>18yo) 0, 1, 6 months	VBI			1ml (>18 yo)	IM: LD RD
ManACWY-D	MedQuadfi	Inject 0.5 ml IM once	Sanofi			0.5 ml (<19 yo) 1ml (>19 yo)	IM: LD RD
Tdap	Boostrix	Inject 0.5 ml IM once	GSK			0.5 ml	IM: LD RD

℞ _____ **PharmD**
Substitution Permitted

Current VIS Given (per Pioneer Rx) ☒
Adverse reaction (if applicaple) and date of notification: _____

Signature of immunizer and Date: _____

Faxed Dr. Powers (Date/Time): _____ **Initials:** _____ **Faxed PCP if applicable (Date/Time):** _____ **Initials:** _____