Vaccine Administration Record

Harbor Drug
114 S Huron Ave
Harbor Beach, MI 48441-1201
Phone: (989) 315-8605 Fax: (989) 479-3242

**********Staff only: **********
Sale Completed in Pioneer ☐
Entered into MCIR ☐
Faxed to provider ☐

Patient Information:

Name: _____ Male: ☐ Female: ☐ Date of Birth: _____ Age: _____

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

Phone: _____ Allergies: _____ Race: _____

Primary Care Physician*: _____ Office Phone Number: _____

Office Fax Number: _____

** Harbor Drug will send vaccination information from this visit to the doctor/primary care provider using the information provided above.*

Screening Questions:

The following questions will help us determine your eligibility to be vaccinated today:

1.	Are you sick today?	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.	Has any physician or other healthcare professional ever cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a medical setting?	Yes	No
5.	Do you have a long-term health problem such as heart disease, lung disease, liver disease, asthma, kidney disease, metabolic disease (e.g., diabetes) anemia or other blood disorder?	Yes	No
6.	Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem? Have you been diagnosed with rheumatoid arthritis, ankylosing spondylitis, Crohn?s disease, herpes, or cold sores?	Yes	No
7.	In the past 3 months, have you taken medications that weaken your immune system such as cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?	Yes	No
8.	Have you had a seizure or a brain or other nervous system problem or Guillain Barre?	Yes	No
9.	During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or antiviral drug (including acyclovir famciclovir, valacyclovir)?	Yes	No
10.	For women: Are you pregnant or is there a chance you could become pregnant during the next month?	Yes	No
11.	Have you received any vaccinations or TB skin test in the past 4 weeks?	Yes	No
12.	Do you have a history of fainting, particularly with vaccines?	Yes	No
13.	For Tdap and adult Td: Do you have a cut, injury, puncture or open wound that prompted you to get a tetanus shot?	Yes	No
14.	For Shingles: Have you had a past reaction to gelatin or triple antibiotic ointment?	Yes	No

Consent:

I certify that I am: (a) the patient and at least 18 years of age; (b) the parent or legal guardian of the minor patient; or (c) the legal guardian of the patient. Further, I hereby give my consent to Harbor Drug, Inc and the licensed healthcare professional administering the vaccine, as applicable (each an “applicable Provider”), to administer the vaccine(s) I have requested above. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine(s) and have received, read, and/or had explained to me the Vaccine Information Statements (VIS) on the vaccine(s) I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. Further, I acknowledge that I have been advised to remain in the store and in sight of a sales associate for observation for 15 minutes (or 30 minutes in some circumstances) after administration. If, after leaving the store, I experience a severe reaction, I will call 9-1-1 or go to the nearest hospital. I will also contact Harbor Drug to notify them of my reaction. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless each applicable provider, its staff, agents, successors, and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above. I authorize the applicable Provider to (a) submit a claim to my insurer for the above requested items and services and (b) request payment of authorized benefits be made on my behalf to the applicable Provider with respect to the above requested items and services. I further agree to be fully financially responsible for any cost-sharing amounts, including copays, coinsurance, and deductibles, for the requested items and services, as well as for any requested items and services not covered by my insurance benefits. I understand that any payment for which I am financially responsible is due at the time of service or, if the applicable Provider invoices me after the time of service, upon receipt of such invoice.

Signature _____ **Date** _____

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Administration (Pharmacist Use Only)

Vaccine	Route & Site of Administration	Lot, Expiration Date, and dose amount or product sticker.			Clinician's initials, adminstration date & time
Influenza	LD RD				
Pneumococcal Polysaccharide (PPSV23)	LD RD				
Pneumococcal Conjugate (PCV15 or PCV20)	LD RD				
Herpes Zoster (Shingrix)	LD RD				
RSV for adults (Arexvy or Abrysvo)	LD RD				
Tetanus (Tdap/Adacel)	LD RD				
COVID	LD RD LD RD				
Other	LD RD				

☐ Review the VIS or EUA & v-safe form with the patient
Date of VIS, EUA, V-safe: _____

☐ Educate patient about second dose and scheduled second dose in calendar if applicable
Next dose due: _____ Scheduled appointment date/time: _____