LEO'S LAKESIDE PHARMACY VACCINE ADMINISTRATION RECORD (VAR)

Name: _____

First Name **Last Name** **Date of Birth (DOB)**

Address: _____ **Phone #:** _____

Street City State Zip **Gender**: ◯ FEMALE ◯ MALE

Race: ◯ American Indian/Alaska Native ◯ Asian ◯Native Hawaiian/Other Pacific Islander ◯ Black/African American ◯White

Ethnicity: ◯ Hispanic or Latino ◯ Not Hispanic or Latino ◯ Unknown Ethnicity

I want to Receive following Vaccine: ◯ Covid-19 1st /2nd/3rd or Booster _____ ◯FLU ◯Pneumonia-13 ◯Pneumonia 23 ◯Shingles

Medicare Part B ID (Red & Blue card): _____ **In uninsured:** Driver License: _____

Primary Care Doctor: _____

Doctor Name Address Fax Number

SCREENING QUESTIONS	YES	NO	Don't Know
(1) Do you feel sick today?			
(2) Do you have an allergy to medications, foods, or any vaccines (eggs, gelatin, thimerosal, neomycin, gentamycin, latex, aluminum, preservatives, baker's yeast, etc.)?			
(3) Have you received any vaccination or skin tests in the past 4-8 weeks? If yes please list:			
(4) Have you ever had a serios reaction or fainted after receiving a vaccination?			
(5) Have you ever had a seizure disorder, brain disorder or Guillain-Barre syndrome?			
(6) **For women**: Are you pregnant or considering becoming pregnant in the next month?			
(7) Do you have a chronic condition or long -term health problem such as cancer, heart disease, lung disease, asthma, kidney disease, diabetes, anemia or other blood disorders? If yes circle one			
(8) Are you currently on home infusions, weekly injections, steroid therapy, anticancer drugs or radiation therapy?			
(9) Do you have cancer, leukemia, lymphoma, HIV/AIDS or any other immune system disorder or are you in contact with anyone who has a severely weakened immune system?			
(10) Have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug during the past year?			
For COVID-19 vaccine only: (11) Have you been diagnosed with or tested positive for COVID-19 in the last 14 days?			
(12) In the past 14 days have you been identified as a close contact to someone with COVID-19?			
(13) **Have you been treated with antibody therapy specifically for COVID-19 (monoclonal antibodies or convalescent plasma)?**			
(14) Have you ever received the dose of covid-19 vaccine? If yes which product you receive? ◯ Pfizer ◯Moderna ◯Janssen (J & J) If yes Dose number & Date: _____and today will get Dose: _____			

IF YOU ANSWERED YES TO ANY QUESTION, YOU MUST TALK TO YOUR PHARMACIST BEFORE BEING VACCINATED

CONSENT AND WAIVER: I hereby give my consent to Leo's Lakeside Pharmacy, as applicable to administer the vaccination(s) I have requested above. I understand the benefits and risks of receiving this vaccine and have received, read and/or had explained to me the Vaccine Information Sheet (VIS) on the vaccine(s) I have elected to receive. I acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. I acknowledge that I have been advised to remain near the vaccination area for ~20 minutes after administration for observation by the administering healthcare provider. On behalf of myself, my heirs and personal representatives, I fully release and discharge Leo Lakeside Pharmacy, its staff, agents, successor, affiliates, officers and employees from any and all liabilities or claims whether known or unknown arising in any way related to the administration of the vaccine(s) listed above. I understand the purpose/benefits of my state's immunization registry and acknowledge that, depending upon my state law, I may prevent disclosure of my immunization to the state registry with a signed Opt-out form. I acknowledge that I have received a copy of the pharmacy's privacy policies according to HIPAA. I assign payment of authorized insurance benefits to me to be paid to the pharmacy. I consent to the release of medical information, when necessary, for billing, reimbursement and medical protocol. I am aware an immunization certified student pharmacist might be administering this vaccine.

If receiving COVID-19 vaccines: I acknowledge that I was advised to wait at least 15 or 30 minutes after the administration of the vaccine for observation by the administering healthcare provider.

Patient Signature/ Legal Guardian: _____ **Date:** _____

HEALTHCARE PROVIDER ONLY:

Vaccine	Lot #	Exp Date	Manufacturer	Dosage	Site of Adm. Deltoid Arm		Route (IM, SQ)	Diluent Lot # (if applicable)	Diluent Expiration (if applicable)	VIS/EUA DATE	VIS/EUA DATE GIVEN	PCP NOTIFIED? Y or N - Date/Time
					L	R						
					L	R						

Pharmacist Name (Print): _____ Immunizing Pharmacist Signature: _____

Intern Name (Print): _____ Administration Date: _____

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