Vaccine Administration Record

Utah Family Pharmacy
utahfamilypharmacy.com

Phone: (435) 635-8200 Fax: (435) 635-4938

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

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

Phone: _____ Allergies: _____ Race: _____

Primary Care Physician: _____ Office Phone Number: _____

INSURANCE

Bin #:_____ ID#:_____

Group #:_____ PCN:_____

MEDICARE

ID#:_____

Name on Card_____

Screening Questions

1. Yes No Are you sick today?
2. Yes No Do you have allergies to medications, food, eggs, yeast, a vaccine component, or latex?
3. Yes No Have you ever had a serious reaction after receiving a vaccination?
4. Yes No Has any physician or other healthcare professional ever cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a medical setting?
5. Yes No 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?
6. Yes No Have you had a seizure or a brain or other nervous system problem or Guillain-Barre?
7. Yes No For women: Are you pregnant or is there a chance you could become pregnant during the next month?
8. Yes No Do you have a history of fainting, particularly with vaccines?

_____

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 certify that I am at least 18 years old and hereby give my consent to the pharmacists of this Mutual Member Drug Store to administer the vaccine(s). If under 18 years old signature by parent or guardian is required. I, on behalf of myself, my heirs, executors, personal representatives, agents, successors, and assigns hereby agree to release, indemnify, and hold harmless Mutual Drug, 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 agree to wait near the vaccination location for approximately 15 minutes for observation by the pharmacist.

Name (print) _____ Signature_____ Date_____

Administration (Pharmacist Use Only)

Vaccine	Product Name	Manufacturer	NDC	Lot	MFG Date	Exp Date	Dose	Site of Injection	Date of VIS	Signature of administrator of vaccine
Covid-19	Covid-19	Moderna	80777-0273-99	041L20A	11/25/20	07/03/21	0.5ML IM	LD RD		
								LD RD		
								LD RD		