Vaccine Administration Record

Marra's Pharmacy
217 Remsen St
Cohoes, NY 12047-3024 Phone: (518) 237-2110 Fax: (518) 237-5533

Name:	Male:	Female:	Date of Birth:	
Address:	City:		State:	Zip:
Phone:	Allergies:	Race:		Ethnicity
Primary Care Physician:	Office Phone Number:			

Screening Questions

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 to 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 disorders?	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 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 tests in the past 4 weeks?	Yes:	No:
12. Do you have a history of fainting, particularly with vaccines?	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 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 Marra's 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 Marra's Pharmacy to administer the vaccine(s). If under 18 years old signature by parent of guardian is required. I agree to wait near the vaccination location for approximately 15 minutes for observation by pharmacist.

Name (print):	Signature:	Date:

Administration (Pharmacist Use Only)

Vaccine	Product Name	Manufact-ure	Lot	Exp. Date	Dose	Site of Injection	Date of VIS/EUA	Signature of Administrator of Vaccine
Influenza QUAD	Fluarix	GLAXO			.5 ml	LD: RD:	8/7/2015	
Pneumococcal Polysaccharide (PPSV23)	Pneeumovax 23	Merck			.5 ml	LD: RD:	4/24/2015	
Pneumococcal Conjugate (PCV 13)					.5 ml	LD: RD:	11/5/2015	
Herpes Zoster	Shingrix	GSK			.5 ml	LD: RD:	2/12/2018	
COVID-19	Moderna Covid-19	Moderna			.5 ml	LD: RD:	3/26/2021	
COVID-19	Janssen COVID-19	Jsn & J&J			.5 ml	LD: RD:	3/19/2021	
COVID- 19	Pfizer Covid-19	Pfizer			.5 ml	LD: RD:	4/6/2021	
Tetanus-Diphtheria (Td)	Tenivac	Sanofi			.5 ml	LD: RD:	4/11/2017	
Tetanus, Diphtheria Toxoids & Acellular Pertussis (Tdap)	Boostrix	GSK			.5 ml	LD: RD:	2/24/2015	