VACCINE/LAI ADMINISTRATION FORM

Health park pharmacy

8300 Health Park Ste 227
Raleigh NC 27615
919.847.7645
919.847.7645p 919.847.7641f

Full Name :

Full Address :

Date Of Birth : D D M M Y Y Phone: Male: Female:

E-Mail : Race : Primary Care Provider

Screening Questions

Are you sick today?	Yes	No
Do you have allergies to food, medication or latex?	Yes	No
Have you ever had a serious reaction to ANY vaccination?	Yes	No
Has a healthcare provider ever cautioned/warned you about receiving vaccines outside of a medical setting?	Yes	No
Do you have a long term health condition such as: heart disease, lung disease, liver disease, asthma, kidney disease, metabolic disease, diabetes, anemia or other blood disorder?	Yes	No
Do you have cancer, leukemia, HIV/AIDs, or any disorder impacting your immune system?	Yes	No
Have you been diagnosed with rheumatoid arthritis, ankylosing spondylitis, Chrone's, herpes, or cold sores?	Yes	No
In the past 3 mo have you taken medication that may weaken your immune system? (ex Prednisone, cortisone, injectable Biologics, chemo or radiation treatment?	Yes	No
Have you been diagnosed with Guillain Barre Syndrome, epilepsy, or other neurological condition?	Yes	No
Over the past year have you had a blood transfusion, been given immune gamma globulin, or received an antiviral drug (including acyclovir, famciclovir, or valacyclovir)?	Yes	No
Are you pregnant or is there a chance you may become pregnant during the next month?	Yes	No
Have you received any vaccinations or TB Tests in the past 4 wks?	Yes	No
Do you have a history of fainting (particularly after receiving a vaccination)?	Yes	No
If you're receiving TdaP today : Do you have a puncture, or open wound that prompted this shot?	Yes	No
If you're receiving Zoster: Have you had a past reaction to gelatin or triple antibiotic oint ?	Yes	No

CONSENT: I have read or have had read to me written information regarding vaccines being administered. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits & risks of the vaccine(s) being administered & have received a copy of the Vaccine Information Sheet (VIS). I, on behalf of myself, my heirs, executors, personal representatives, agents, successors & assigned hereby agree to release, hold harmless and indemnify Health Park Pharmacy, LLC, its subsidiaries, divisions, affiliates, agents, officers, directors, contractors & employees from any & 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 & hereby give my consent to the pharmacists & nurses of Health Park Pharmacy, LLC to administer the vaccine(s). If under 18 years old, signature of parent or guardian is required. I agree to wait near the vaccination location for 15-30 min based on risk factors

Name (print): _____ Signature: _____ Date: _____

Administration (Pharmacist/Nurse Use Only)

Vaccine	Product Name	Mfg	Lot	Exp	Dose	Site	Date of VIS	Signature of vaccine administrator
Influenza								
Pneumococcal (PPSV23)								
Pneumococcal (PCV12)								
Shingles								
Hep A								
Hep B								
Meningitis								
TdaP								
COVID								
RSV								
Long Acting Injection								