COMMUNITY PHARMACIES

Randolph	1447247846	Gorham	1538156807	Cornish	1760587232
Bucksport	1881681286	Corinth	1700873122	Waldoboro	1124362934
Saco	1275520686	Blue Hill	1013961549	Hermon	1538536180

VACCINE/FLU CONSENT & ADMINISTRATION RECORD

Name:	**Date of Birth:**	**Age:**	
Address:	**City:**	**State:**	**Zip Code:**
Gender: ◯ **Male** ◯ **Female** ◯ **Non-Binary**	**Primary Care Provider:**	**Phone #:** ◯ **Cell** ◯ **Home**	

Race *****Required*** ◯ White ◯ American Indian or Alaska Native ◯ Asian ◯ Native Hawaiian or other Pacific Islander ◯ Black or African American ◯ Other

Ethnicity *****Required*** ◯ Hispanic or Latino ◯ Not Hispanic or Latino ◯ Unknown

INSURANCE CARD, LICENSE or ID REQUIRED

Medicare Eligible? Yes No	Commercial Ins. Name:	Uninsured? Yes No	
Medicare B #: (red, white & blue card)	Rx Policy #:	By selecting **YES** I am attesting that I **do not** have insurance	
	Rx Bin:	License #:	
Or Social Security #:	Rx PCN:	**OR**	———————-
	Rx Group:	SSN #:	

Please read and answer the questions below for the person receiving the vaccine(s) today	**YES**	**NO**	**Comment**
1- Do you feel sick today?	_____	_____	_____
2- Do you have allergies to medications, food latex or any vaccines?	_____	_____	_____
3- Have you ever had a serious reaction after receiving a vaccination?	_____	_____	_____
4- Do you have cancer, leukemia, AIDS, or any other immune system problem?	_____	_____	_____
5- Do you take cortisone, prednisone, or other steroids or anticancer drugs, or xray treatments?	_____	_____	_____
6- Do you have a seizure, brain or nerve problem?	_____	_____	_____
7- During the past year, have you received a transfusion of blood or blood products?	_____	_____	_____
8- Have you been given a medicine called immune (gamma) globulin?	_____	_____	_____
9- For women: Are you pregnant or is there a chance you could become pregnant in the next month?	_____	_____	_____
10- Have you received <u>any other</u> vaccinations in the past 4 weeks. Ex: pneumonia, shingles, flu	_____	_____	_____

11–**<u>COVID ONLY</u>** - How many COVID-19 vaccinations have you received? (not including today)

1st_____ 2nd _____ 3rd _____ 4th _____ 5th _____

Please read the following statements and sign below:

I have read, or have had read to me, the information regarding the vaccine(s) being administered today. I have had the opportunity to ask questions that were answered to my satisfaction. I have been informed to wait at least 15 minutes after vaccine administration. I give my permission for the pharmacist providing this immunization to administer epinephrine, diphenhydramine, or both, to me/my child in the case of an adverse reaction to the drug or immunization administered. I understand the benefits and risks of the vaccine(s). I acknowledge that I have been offered a copy of the pharmacy's Notice of Privacy Policies. I consent to, or give consent for, the administration of the vaccine.

Signature:_____ **Date:**_____

For Clinic Use:	
Date Administered:	
Vaccine Name:	COVID-19 | FLU
Manufacturer:	
Lot Number:	
Expiration Date:	
Route:	IM
Site:	LD | RD
Dose: (ML)	0.2 | 0.25 | 0.5 | 0.3 | 0.7
EUA | VIS Version (pub date):	
Date and to whom EUA | VIS provided:	
Vaccine Administrator:	

☐ Check if COVID & Flu given same day

Pharmacy Label

Updated August 19, 2022