PATIENT IMMUNIZATION ADMINISTRATION

Patient Name: _____ DOB: _____/_____/_____

Address: _____ Phone Number: _____

Patient Signature: _____

Parent Name (if under 18): _____ Parent Signature: _____

	Yes	No	Don't Know
1. Are you sick today?	☐	☐	☐
2. Do you have allergies to medications, food, latex or vaccine component?	☐	☐	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☐	☐
4. Do you have any long-term health problems with heart, kidney and/or lung disease, asthma, metabolic disease (e.g. diabetes, anemia or other blood disorder?	☐	☐	☐
5. Do you have cancer, leukemia, HIV/AIDS or any other immune system problem?	☐	☐	☐
6. In the past 3 months, have you taken medications that weaken your immune system such as cortisone, prednisone, other steroids, anti-cancer drugs, or have you had radiation treatment?	☐	☐	☐
7. Have you had a seizure or brain or other nervous system problem?	☐	☐	☐
8. During the past year, have you received a transfusion of blood or blood products or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
9. Women: Are you pregnant or is there a chance you could be pregnant during the next month?	☐	☐	☐
10. Have you received any vaccinations in the past 4 weeks?	☐	☐	☐

Lot: _____ Exp: _____

Route: IM SQ

Locations Administered: _____

Administering Pharmacist: _____