Harrold's Pharmacy

179 Old River Rd Wilkes-Barre, Pa 18702

VACCINE CONSENT & ADMINISTRATION RECORD

Harrold's Pharmacy will keep this record in your medical file. Please complete the top portion of this form.

Name (Last, First MI):			Date of Birth:
Address:			Gender: M F
City:	State:	Zip Code:	Phone Number: ( )
Primary Physician:	Physician Address:		

Please check the vaccine(s) to be administered today.

_____ Influenza (Flu) Injection

Please read the questions below and indicate **YES** or **NO** for the person receiving the vaccine(s) today.

Questions	NO	YES	Comment
1. How are you today? Do you have a substantial fever, diarrhea or vomiting today?	o	o	
2. Have you ever had a severe reaction to any vaccine, which required medical care?	o	o	
3. Are you allergic to eggs (influenza), baker's yeast, gelatin, streptomycin (OPV) or neomycin (MMR, poliovirus)?	o	o	
4. Are you or is anyone living with you being treated with chemotherapy, radiation for cancer, have HIV/AIDS, or any immune deficiency disease?	o	o	
5. Are you being treated by a doctor for any disease or illness? Which medications do you take (note below)?	o	o	
6. Have you received blood or antibodies (immune globulins) in the past year? *If yes, when?*	o	o	
7. Are you pregnant, or planning to become pregnant in the next three months?	o	o	

** Please list all prescription or over-the-counter medications that this person is taking:

**Please list all food and drug allergies:

I have read, or have had read to me, the information regarding the vaccine(s) marked above. I have received a copy of the vaccine information statement regarding the vaccine(s) marked above. I have had the opportunity to ask questions that were answered to my satisfaction. I have been informed to wait in the pharmacy at least 15 minutes after vaccine administration. I understand the benefits and risks of the vaccine(s). I consent to, or give consent for, the administration of the vaccine(s) marked above to:

Parent Signature _____ **Date** _____

For Clinic/Office Use:

Vaccine Name: _____ Dose Administered: _____
Manufacturer: _____ Date Administered: _____
Lot Number/Exp: _____ Vaccine Administrator: _____
Site of Administration: _____ Signature: _____