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: _____

Mother's Maiden Name: Insurance BIN # Insurance PCN # Insurance Group #

Primary Care Physician: **Medicare #** **SSN #** INS Id #

Please specify which vaccine and dose are you getting today (Eg: Flu Vaccine/ Covid Vaccine/ RSV / Tetanus / Shingles etc...) :_____

For Patients: The following questions will help us determine which vaccineyou may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

Screening Questions

1.	Are you sick today?	Yes	No
2.	Have you ever had a serious reaction after receiving a vaccination ?	Yes	No
3.	Do you have allergies to medications, food, eggs, yeast, a vaccine component, or latex?	Yes	No
4.	Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	Yes	No
5.	Do you have a long-term health problem such as lung disease, liver disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia heart disease (Myocarditis or Pericarditis etc...) or a bleeding disorder, a history of blood clots or are you taking a blood thinner?	Yes	No
6.	Do you have a parent, brother or sister with a immune system problem?	Yes	No
7.	In the past 3 months, have you taken medications that weaken your immune system such as cortisone, prednisone, etc.. or anticancer drugs or have you had radiation treatments or drugs for rheumatoid arthritis or Chron's Disease?	Yes	No
8.	Have you had a seizure or a brain or other nervous system problem or Guillain Barre syndrome?	Yes	No
9.	During the past year, have you received blood/blood products, or been given immune (gamma) globulin or antiviral drug ?	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 test in the past 4 weeks?	Yes	No
12.	Have you ever felt dizzy or faint before, during or after a vaccine shot?	Yes	No
13.	Are you anxious about getting a vaccine shot today?	Yes	No
14.	Have you received a covid vaccine in the past?	Yes	No
15.	If you answered yes to the question 14, is it with in the last 2 months?	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 a 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 or guardian is required. I agree to wait near the vaccination location for approximately 15 minutes for observation by the pharmacist.

☐ By checking this box you are allowing Marra's Pharmacy to submit your Vaccine to NYS registry

Patient or Patient's Representative/ Guardian Name (PRINT) _____

Patient or Patient's Representative/ Guardian Signature_____**Date**_____

Administration (Pharmacist Use Only)

Vaccine	Product Name	Lot	Exp Date	Dose	Site of Injection	Date of VIS	Signature of Administrator of Vaccine
Influenza QUAD Regular Infuenza QUAD 65+ (Senior)					LD RD	08/06/2021	
Pneumococcal Conjugate (PCV13, PCV15, PCV 20)					LD RD	05/12/2023	
Pneumococcal (PPSV23)					LD RD	10/30/2019	
Herpes Zoster					LD RD	02/04/2022	
RSV Vaccine					LD RD	07/24/2023	
Tetanus,Diphtheria Toxoids & Acellular Pertussis (Tdap)					LD RD	08/06/2021	
COVID-19					LD RD		
Other: _____					LD RD		