312-B Marion Ave
McComb, MS 39648

601-684-4127 • 800-704-3647
Fax: 601-684-8479

Vaccine Administration Record

Name _____ Age _____

Date of Birth _____ Phone _____

Address _____

City _____ State _____ Zip Code _____

E-mail _____

Gender: Male ☐ Female ☐ Married: Yes ☐ No ☐ Today's Date _____

Primary Care Physician _____

Method of Payment: Cash ☐ Check ☐ Medicare ☐ - Medicare # _____

Please read the questions below and indicate Yes or No for the person receiving the vaccination today	Yes	No
Are you sick today or do you currently have a fever or infection?		
Has this person ever had a severe reaction to any vaccine, which required medical care?		
Is this person allergic to eggs, baker's yeast, streptomycin, neomycin, thimerosal, and vaccine, or any vaccine component?		
Do you, and person who lives with you, or any person you take care of have cancer, leukemia, HIV/AIDS, and immune disorder, or are being treated with chemotherapy or radiation for cancer?		
Do you, any person who lives with you, or any person you take care of take cortisone, prednisone, or any other steroid?		
Does this person smoke? If you are under 18 years old, does anyone in the household smoke?		
Is this person receiving treatment for any disease or illness?		
Has this person been under a doctor's care in the past year?		
During the past year, has this person received a transfusion of blood or plasma, or been given a medicine called *immune globulin*?		
For women: Is it possible that you are pregnant or may become pregnant in the next three months?		

(↓ For use at time of vaccination ↓)

Consent for Administration of Vaccine

I have read, or have had read to me, the information regarding the vaccine(s) marked below. I certify that I am at least 18 years old and hereby give my consent to, or give consent for, the staff of Guy's Innovative Pharmacy Services to administer the vaccine(s) marked above to myself, or the persons for whom I am authorized to make this request. I understand that it is not possible to predict all possible side effects or complications associated with vaccines. I understand the possible risks associated with the above marked vaccines as provided in the Vaccine Information Statement (VIS) that was provided to me. I have had the chance to ask questions regarding each of the above marked vaccines and have received answers to these questions that met with my satisfaction. I, on behalf of myself, my heirs, executors, personal representatives, agents, successors, and assigns hereby agree to release, indemnify, and hold harmless Guy's Innovative Pharmacy Services, its affiliates, agents, directors, and employees from any and all claims arising out of, in connection with, or in any way related to the administration of the vaccines marked above.

This information is true and correct to the best of my knowledge and I hereby acknowledge that my protected health information covered under HIPAA has been explained to me and that a printed copy is available to me upon request.

Signature: _____ Date: _____

(↓ HEALTH CARE PROVIDERS ONLY ↓)

Vaccine	Date	Manufacturer and Lot #	Site	Initials
Flu			L / R	
Pneumonia			L / R	