Date Faxed to Provider
Initials of Sender
Fax Number

Vaccine Administration Record

Check All Vaccines You Are Requesting Today:

☐ Influenza	☐ Hepatitis A	☐ Japanese Encephalitis	☐ Rabies
☐ Pneumonia	☐ Hepatitis B	☐ MMR	☐ Td or Tdap
☐ Shingles	☐ HPV	☐ Meningitis	☐ Typhoid
☐ Cholera	☐ H. Influenzae type B (Hib)	☐ Polio	☐ Varicella

Name, Last:____________________ First:______________________ Middle:________

Preferred Name:____________ Pronouns:____________ Date of Birth:________ Weight:____

Legal Sex:____________ Gender Identity:____________ Assigned Sex at Birth:____________

Address:____

City:______________________ State:_____ Zip:__________ County:____________

Phone:__________________ Allergies:______________________________________

Physician Name:____

Physician Address:____

I authorize the pharmacy to send copies of my vaccine documents to my primary care provider. ☐ Yes ☐ No

FOR OFFICE USE ONLY				
Pharmacy/Clinic Name and Address **(circle one)**	Equitas Health Pharmacy 1033 N High Street Columbus, OH 43201	Equitas Health Pharmacy 1222 S Patterson Blvd, Ste 110 Dayton, OH 45402	Equitas Health Pharmacy 736 E Long St Columbus, OH 43203	Equitas Health Pharmacy 2805 Gilbert Ave Cincinnati, OH 45206
Date Vaccines Administered:________	**Vaccine #1**	**Vaccine #2**	**Vaccine #3**	**Vaccine #4**
Injection Administered				
Manufacturer				
Lot #				
Expiration Date				
Dose/Amount				
Site of Injection				
Route				
Needle Gauge				
Needle Length				
VIS Version Date				
Other Medications Administered (e.g. epinephrine, etc.)				

Signature / Title of Vaccinator (RPh or Intern)	Signature of Supervising RPh (If Intern Administered)

Continued On Other Side

Equitas Health Pharmacy

Vaccine Administration Record

Patient Questions	Yes	No	Not Sure
1. Are you feeling ill today or do you have a fever?	☐	☐	☐
2. Are you currently taking an antibiotic for an infection?	☐	☐	☐
3. Do you have an allergy to medications, foods (e.g. eggs) or any component of the vaccine (gelatin, neomycin, polymyxin, yeast, thimerasol, etc.)? If yes, please list what you are allergic to: ______________________	☐	☐	☐
4. Are you allergic to latex?	☐	☐	☐
5. Have you ever had a serious reaction to vaccines in the past?	☐	☐	☐
6. Have you received any vaccinations in the past 4 weeks?	☐	☐	☐
7. Have you ever had Guillain-Barre syndrome?	☐	☐	☐
8. Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
9. Do you have any severe long-term health problems with heart disease or lung disease?	☐	☐	☐
10. Do you currently have cancer, leukemia, or any other immune system problem?	☐	☐	☐
11. Are you currently undergoing chemotherapy or radiation therapy, or planning to in the near future?	☐	☐	☐
12. In the past 3 months, have you taken medications that weaken your immune system (e.g. prednisone/other steroids or cancer treatments)?	☐	☐	☐
13. Do you have HIV/AIDS? If so, please state your CD4 count: ______________________	☐	☐	☐
14. Do you have tuberculosis? If yes, are you currently receiving treatment?______________________	☐	☐	☐
15. Do you have a bleeding disorder or take any anticoagulation medications?	☐	☐	☐
16. Have you received any blood transfusions in the past year?	☐	☐	☐
17. Have you had a seizure, brain disorder, or other nervous system problem?	☐	☐	☐

I hereby certify that the foregoing history is true and complete to the best of my knowledge, and I request the selected vaccine(s). I understand the benefits and risks of the vaccine(s), and ask that the vaccine(s) be given to me. I have received a copy of the Equitas Health Pharmacy's Privacy Practices and realize that Equitas Health may bill my insurance if that is possible and appropriate.

I have read or have had explained to me the information in the Vaccine Information Statement about the selected vaccine(s). I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the selected vaccine(s) and ask that the vaccine(s) be given to me or the person named above for whom I am authorized to make this request.

For Medicare Recipients: I authorize the release of any medical or other information necessary to process the claim. I also request payment of government benefits either to myself or to the party who accepts assignment.

Signature Authorizing Vaccination; of person to receive vaccine or authorized to make request for vaccination	**Date**

Patient Signature above and Vaccinator signature also indicates patient receipt of the Vaccine Information Statement for the selected vaccination(s) on date signed.

Continued On Other Side