



Vaccine Administration Record

ALPS Pharmacy Nixa
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Nixa, MO 65714-6206
Phone: (417) 725-5252 Fax: (417) 893-3909

Patient Name: _____ Date of Birth: _____ Male: ___ Female: ___
Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Race/Ethnicity: _____
SSN: _____ BIN: _____ PCN: _____ Group: _____ Member ID: _____ Insurance Name: _____

Screening Questions	YES/NO	Do you need help with any of the following?:
1. Are you sick today? (Pharmacy staff-list current temperature: _____)	YES/NO	<input type="checkbox"/> Transportation insecurity
2. Do you have allergies to medications, food, eggs, yeast, a vaccine component, or latex?	YES/NO	<input type="checkbox"/> Access to care
3. Have you ever had a serious reaction after receiving a vaccination?	YES/NO	<input type="checkbox"/> Financial insecurity
4. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	YES/NO	<input type="checkbox"/> Problems related to health literacy
5. In the past 3 months, have you taken medications weakening your immune system such as steroids, anticancer drugs, or radiation treatment?	YES/NO	<input type="checkbox"/> Lack of adequate food
6. Have you had a seizure or a brain or other nervous system problem or Guillain Barre?	YES/NO	<input type="checkbox"/> Inadequate housing
7. Are you pregnant or potentially could become pregnant during the next month?	YES/NO	<input type="checkbox"/> Problems associated with living alone
8. Have you received any vaccinations or a TB skin test in the past 4 weeks?	YES/NO	<input type="checkbox"/> Lack of insurance, un/underinsured
		<input type="checkbox"/> Other: _____
		Do you identify as having a disability? YES/NO (i.e. hearing/vision/cognitive/self-care/independent living)

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 ALPS 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 ALPS 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. I consent to my vaccination record being sent to the ShowMeVax database. If your insurance denies payment, you will be billed for the services rendered.

Name (print): _____ If guardian check this box: ShowMeVax opt out:
Signature: _____ Date: _____

Notes: _____

CHW Initials: _____

Administration (Pharmacist Use Only) Clinic Name: _____ Address: _____

Clinic Type: Home/ Nursing Home/ Community Center/ Place of Worship/ Pharmacy/ Other: _____

Vaccine	Product Name	Administration Direction	Mfr	Lot	Exp Date	Dose	Site of Injection	Vaccines Discussed	Intervention
Influenza Quadrivalent Multi-Dose Vial	Fluzone MDV/ Afluria MDV	Inject 0.5mL IM once	Sanofi / Seqirus			0.5 mL	IM: LD RD	<input type="checkbox"/> Not Eligible or C/I <input type="checkbox"/> Up to Date <input type="checkbox"/> Eligible	<input type="checkbox"/> Counseled on hesitancy <input type="checkbox"/> Referred for F/U Assessment/Plan:
Influenza Quadrivalent Pre-Filled Syringe	Afluria PFS	Inject 0.5mL IM once	Seqirus			0.5 mL	IM: LD RD	<input type="checkbox"/> Not Eligible or C/I <input type="checkbox"/> Up to Date <input type="checkbox"/> Eligible	
Influenza Adjuvanted (>65 yo)	Fluad	Inject 0.5mL IM once	Seqirus	388493	4/30/25	0.5 mL	IM: LD RD	<input type="checkbox"/> Not Eligible or C/I <input type="checkbox"/> Up to Date <input type="checkbox"/> Eligible	
Pneumococcal 20-valent	Pevnar 20	Inject 0.5mL IM once	Pfizer			0.5 mL	IM: LD RD	<input type="checkbox"/> Not Eligible or C/I <input type="checkbox"/> Up to Date <input type="checkbox"/> Eligible	
Herpes Zoster	Shingrix	Reconstitute and Inject 0.5mL IM once	GSK			1st 0.5mL 2nd 0.5mL	IM: LD RD	<input type="checkbox"/> Not Eligible or C/I <input type="checkbox"/> Up to Date <input type="checkbox"/> Eligible	
Hepatitis B (>18yo)	PreHevbrio/ Hepsiv-B	Inject 1mL IM once Inject 0.5 mL IM once	GSK			1 mL 1st 0.5mL 2nd 0.5mL	IM: LD RD	<input type="checkbox"/> Not Eligible or C/I <input type="checkbox"/> Up to Date <input type="checkbox"/> Eligible	
MenACWY-D	Menquadfi	Inject 0.5mL IM once	Sanofi			0.5 mL	IM: LD RD	<input type="checkbox"/> Not Eligible or C/I <input type="checkbox"/> Up to Date <input type="checkbox"/> Eligible	
Tetanus, Diphtheria, & pertussis (TDap)	Boostrix	Inject 0.5mL IM once	GSK			0.5 mL	IM: LD RD	<input type="checkbox"/> Not Eligible or C/I <input type="checkbox"/> Up to Date <input type="checkbox"/> Eligible	
Covid-19		Inject 0.5mL IM once				0.5 mL	IM: LD RD	<input type="checkbox"/> Not Eligible or C/I <input type="checkbox"/> Up to Date <input type="checkbox"/> Eligible	

Rx PharmD
Substitution Permitted

Current VIS Given (per Pioneer Rx)
Adverse reaction (if applicable) and date of notification: _____

Signature of immunizer and Date: _____

RPh Supervisor (if applicable): _____ Faxed PCP if applicable (Date/Time): _____ Initials: _____