

I have received a copy of the notice of Privacy Practices. I understand the notice of Privacy Practices provides an explanation of the ways in which my health information may be used or disclosed by the Pharmacy and my rights with respect to my health information, including reporting to the State Vaccination Registry and/or local or state Departments of Health, federal Department of Health and Human Services, and the Center for Disease Control and Prevention.

Signature of Person to Receive Vaccine (or Parent/Guardian, if a minor):

_____ Date: _____

(Print Parent/Guardian name if recipient is a minor): _____ Date: _____

To be completed by Vaccine Administrator

Vaccine	Date Administered	Vaccine Lot#	Expiration Date	MFR	Dosage	Injection Site	VIS/EUA Date	Dose #1 or #2

Administering Immunizer Signature: _____ Date: _____