

# Vaccine Administration Record - Rabies Vaccine

Name \_\_\_\_\_ Date \_\_\_\_\_

Employer/Department \_\_\_\_\_

SSN \_\_\_\_\_ Med. Record Number \_\_\_\_\_

### PLEASE PRINT

Are you now receiving the rabies vaccine?  Yes  No

Have you ever had a reaction to an immunoglobulin shot?  Yes  No

Have you had any other immunizations in the past three months?  Yes  No

Are you currently sick with any acute or chronic illness?  Yes  No

Are you currently taking any medicine to thin your blood such as Coumadin or have any history of bleeding or clotting problems?  Yes  No

Are you on any immunosuppressive drugs or steroids or suffer from any immune system disorder?  Yes  No

Have you ever had a reaction to or were told you are allergic to glycerin?  Yes  No

If you answered yes to any of the above problems, please provide details: \_\_\_\_\_

\_\_\_\_\_

If female, is there any chance you could be pregnant?  Yes  No

If female, are you breast-feeding?  Yes  No

I have read or have had explained to me the information about the Rabies Vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of Rabies Vaccine. I request that the vaccine be given to me.

Signature \_\_\_\_\_ Date \_\_\_\_\_

### DO NOT WRITE BELOW THIS LINE

Manufacturer \_\_\_\_\_ Lot # \_\_\_\_\_ Expiration Date \_\_\_\_\_

Dose: 1 ml IM Site of Injection  Right Deltoid  Left Deltoid

Injection Time \_\_\_\_\_ No reactions after \_\_\_\_\_ minutes of observation

Reaction, if any: \_\_\_\_\_ VIS Given? \_\_\_\_\_

Signature of Vaccine Administrator \_\_\_\_\_

Date/Time \_\_\_\_\_

Pre-exposure Series: Day 0  Day 7  Day 21 or 28   
Post-exposure Series: Day 0  Day 3  Day 7  Day 14  Day 28   
(If has had pre-exposure series, then post-exposure only requires the first two doses.)