IMMUNIZATION SCREENING AND CONSENT FORM

PATIENT INFORMATION

First Name _____ MI _____ Last Name _____

Email Address _____ Phone _____

Address _____

City _____ State _____ Zip _____ County _____

Date of Birth _____ Age _____ Gender _____

Race
- ☐ American Indian/ Alaska Native
- ☐ Native Hawaiian/ Other Pacific Islander
- ☐ Black/ African American
- ☐ White
- ☐ Asian
- ☐ Other
- ☐ Unknown
- ☐ Unable to report due to policy/law

Appointment Date _____ Appointment Time _____

Ethnicity
- ☐ Hispanic/ Latino
- ☐ Not Hispanic/ Latino
- ☐ Unknown
- ☐ Unable to report due to policy/law

INSURANCE INFORMATION

Type of Insurance _____ Insurance Number _____ Group Number _____

Insurance Provider Name _____ Rx ID _____ BIN _____ PCN _____

PRIMARY CARE PHYSICIAN INFORMATION

Physician's Full Name	Physician's Phone	City
_____	_____	_____

REQUESTED VACCINES

Which vaccine(s) would the patient like to receive today?

☐ Influenza (Injectable)	☐ COVID-19	☐ Meningococcal	☐ MMR
☐ Influenza (Nasal)	☐ HPV	☐ Td	☐ Varicella
☐ Hepatitis A	☐ Zoster (Shingles)	☐ DTaP	☐ RSV
☐ Hepatitis B	☐ Pneumococcal	☐ Tdap	☐ Other

SCREENING QUESTIONS

All Vaccines	**Yes**	**No**	**Don't Know**
1. Are you feeling sick or experiencing a moderate to high fever today?	☐	☐	☐
2. Do you have any allergies to medications, food, latex, vaccine component (e.g. neomycin, formaldehyde, gentamicin, thimerosal, bovine protein, phenol, polymyxin, gelatin, baker's yeast, or yeast)? If yes, please list: _____	☐	☐	☐
3. During the past year, have you received any transfusion of blood or blood products, or been given a medication called immune (gamma) globulin?	☐	☐	☐
4. Have you ever had a serious reaction to any vaccinations, including fainting and feeling dizzy?	☐	☐	☐
5. Do you have any of the following: a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak? Are you on long-term aspirin therapy? If yes, please list: _____	☐	☐	☐
6. Have you ever had a seizure disorder for which you were on seizure medication(s), a brain disorder, Guillain-Barré Syndrome (a condition that causes paralysis) or other nervous system problems?	☐	☐	☐
7. Are you pregnant or considering becoming pregnant in the next month?	☐	☐	☐
8. Do you have cancer, leukemia, HIV/ AIDS, or any other immune system problem?	☐	☐	☐
9. Do you have a parent, brother or sister with an immune system problem?	☐	☐	☐

10. In the past 6 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?	☐	☐	☐
11. Have you ever been diagnosed with a heart condition (myocarditis or pericarditis) or have you had Multisystem Inflammatory Syndrome (MIS-A or MIS-C) after an infection with the virus that causes COVID-19?	☐	☐	☐
12. Did you have a physical examination in the last year? If yes, provide the examination date: _____	☐	☐	☐

Live Vaccines (Chickenpox, Flu Nasal Spray, MMR®II, Oral Typhoid, Shingles, Yellow Fever)

13. Have you received any vaccinations or skin tests within the past four weeks? If yes, please list: _____	☐	☐	☐
14. Do you take cortisone, prednisone, other steroids, anticancer drugs, or have you had any radiation treatments?	☐	☐	☐
15. Do you have a) an open channel between the cerebrospinal fluid (CSF) and the mouth, throat, nose or ear or any other cranial CSF leak, or b) a cochlear implant, or c) an immunocompromising condition due to any cause (e.g., medication, congenital or acquired immunodeficiency, HIV infection, or a missing or non-functioning spleen [e.g., caused by sickle cell disease])?	☐	☐	☐
16. Do you currently take influenza antiviral medications, or have you taken any within the past 3 weeks?	☐	☐	☐
17. Do you live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (e.g., an isolation room of a bone marrow transplant unit)?	☐	☐	☐

Flu Nasal Spray (Flumist®, Quadrivalent)

18. Are you receiving aspirin therapy or aspirin-containing therapy? (18 years of age and younger only)	☐	☐	☐
19. Do you have a nasal condition serious enough to make breathing difficult, such as a very stuffy nose? (For FluMist® only)	☐	☐	☐

Has the patient had the following vaccines?

20. Pneumococcal vaccine	☐	☐	☐
21. Shingles vaccine	☐	☐	☐
22. Tdap (Whooping Cough) vaccine	☐	☐	☐
23. Meningitis	☐	☐	☐

By signing above, I certify that I am: (a) the patient and at least 18 years of age or (b) the parent or legal guardian of the patient. Further, I hereby give my consent to the healthcare provider of "_____", to administer the vaccine(s) I have requested above. I understand the risks and benefits associated with the above vaccine(s) and have received, read and/or had explained to me the Vaccine Information Statements on the vaccine(s) I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. Additionally, it is recommended to wait for 15 minutes following the vaccination before leaving the premises. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless the applicable Provider, its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above. I acknowledge that I understand the purposes/benefits of my state's immunization registry ("State Registry") and the Provider may disclose my immunization information to the State Registry. I acknowledge that, depending upon my state's law, I may prevent the disclosure of my immunization information by the applicable Provider to the State Registry by using the opt-out form. The Provider will, if my state permits, provide me with an Opt-Out Form. I understand that, depending on my state's law, I may need to specifically consent, and to the extent required by my state's law, by signing below, I hereby do consent to the Provider reporting my immunization information to the State Registry. I understand that even if I do not consent or if I withdraw my consent, my state's laws may permit certain disclosures of my immunization information as required or permitted by law. I voluntarily authorize and direct my healthcare provider at "_____" to use or disclose my health information during the term of this Authorization to the physician responsible for this protocol of specific health information of people vaccinated at "_____", my Primary Care Physician, my insurance and/or state or federal registries, where required, for the purpose of treatment, payment or other healthcare operations. I further agree to be fully financially responsible for any cost sharing amounts, including copays, coinsurance, and deductibles, for the requested items and services as well as for any requested items and services not covered by my insurance benefits. I understand that any payment for which I am financially responsible is due at the time of service.

Patient First Name

_____

Patient Last Name

_____

Patient Signature (Parent or Guardian, if minor)

_____

Date

_____

PHARMACY USE ONLY

VACCINES GIVEN

Vaccine	NDC	Manufacturer	Dose	VIS Date	Lot #	Exp Date	Site of Admin	Route of Admin
☐ Influenza (Injectable)							☐ LA ☐ RA	☐ IM
☐ Influenza (Nasal)							☐ LN ☐ RN	☐ Nasal
☐ Hepatitis A							☐ LA ☐ RA	☐ IM
☐ Hepatitis B							☐ LA ☐ RA	☐ IM
☐ Hepatitis A&B							☐ LA ☐ RA	☐ IM
☐ Zoster (Shingles)							☐ LA ☐ RA	☐ IM ☐ SQ
☐ Pneumococcal							☐ LA ☐ RA	☐ IM ☐ SQ
☐ Meningococcal							☐ LA ☐ RA	☐ IM ☐ SQ
☐ Td							☐ LA ☐ RA	☐ IM
☐ Tdap							☐ LA ☐ RA	☐ IM
☐ MMR							☐ LA ☐ RA	☐ SQ
☐ DTaP							☐ LA ☐ RA	☐ IM
☐ Varicella							☐ LA ☐ RA	☐ SQ
☐ HPV							☐ LA ☐ RA	☐ IM ☐ SQ
☐ Hib							☐ LA ☐ RA	☐ IM
☐ COVID-19							☐ LA ☐ RA	☐ IM
☐ RSV							☐ LA ☐ RA	☐ IM
☐ Other							☐ LA ☐ RA	☐ IM ☐ SQ
							☐ LN ☐ RN	☐ Nasal

Administered by (Signature)

_____

Supervising Pharmacist Signature
(if applicable)

_____

Date VIS Given to Patient

_____