2020-21 Immunization Consent Form
and Screening Questionnaire

❖ Personal Information

Patient Name: _____ **Date of Birth**: ____/_____/_____

Gender: Male or Female **Address**: _____

Primary Phone #: Cell or Home (_____)-_____-_____

Emergency Contact Name: _____

Emergency Contact Relationship: _____

Emergency Contact Phone #: Cell or Home (_____)-_____-_____

Primary Care Physician: _____

Primary Care Physician Phone #: (_____)-_____-_____

❖ Screening Questions (Please answer with yes, no, or not applicable)

1. If you are over the age of 50, have you ever had the shingles vaccine? _____
2. If you are over the age of 65, have you ever had a pneumococcal vaccine? _____
3. Are you pregnant or planning on becoming pregnant? _____
4. **Tdap Vaccine Only**: Have you ever had a seizure disorder, brain disorder, or Guillain-Barre Syndrome? _____
5. **Live Vaccine Only**: Have you received any other immunizations in the past four weeks? _____ If yes, please specify: _____
6. **Live Vaccine Only**: Do you have Cancer, Leukemia, HIV, or any other long term health condition (ex. Asthma, Diabetes, etc.) _____ If yes, please specify: _____
7. **Live Vaccine Only**: Do you take cortisone, prednisone, other steroids, anticancer drugs, or have had an X-ray treatment done recently? _____ If yes, please specify: _____
8. **Live Vaccine Only**: Have you received a blood transfusion or have taken a medication called immune (gamma) globulin? _____

❖ COVID-19 Questionnaire

1. Do you have any new signs or symptoms of a respiratory infection, sore throat, cough, shortness of breath, malaise, diarrhea, dizziness, loss of taste/ smell, rash? _____
2. In the last 14 days, have you had contact with anyone confirmed or probable positive case of COVID, respiratory infection, or anyone that has traveled recently? _____
3. Do you reside or work in a community where the spread of COVID is occurring? (Ex. household, apartment building, nursing home, etc.) _____
4. Have you traveled out-of-state recently? _____ If yes, specify the state and dates: _____
5. Have you been exposed to someone with COVID-19 recently? _____

❖ **Signatures**

I understand the benefits and risks involved with the vaccines described in the Vaccine Information Statement (VIS), which has been provided to me with this consent and release form. I request the administration of the vaccination to be given to me or the person named above, a minor for whom I represent and have the authority to sign this consent and release form in the name of.

Signature of Person Receiving Vaccine (or Guardian if recipient is a minor):_____

Print of Guardian Name and Number (if recipient is a minor): _____

I have received a copy of the notice of Privacy Practices and appropriate VIS form courtesy of the CDC. I understand the notice of Privacy Practices and the ways in which my health information may be used or disclosed within the pharmacy and my rights associated with it. I understand the pharmacy complies with the HIPAA law and have been provided an opportunity to discuss concerns in regards to the privacy of my health information.

Signature of Acknowledgement of Privacy Practices, VIS, and HIPAA: _____

I consent to the pharmacy taking my temperature via a non-contact infrared thermometer and recording it on this form. I also agree to wear a mask and follow current CDC recommendations for the safety of pharmacy staff and myself during the vaccine administration.

Signature of Acknowledgement of COVID-19 precautions: _____

Pharmacy Use Only

Vaccine	Date of Administration	Lot #	Exp. Date	MFR	Dosage	Inj. Site	VIS Date
Influenza Vaccine Quad					0.5Ml 0.25Ml	LD RD	08/15/2019
Prevnar13 (PCV 13)				Pfizer	0.5Ml	LD RD	10/30/2019
Penumovax23 (PPSV 23)				Merck	0.5Ml	LD RD	10/30/2019
Zoster (Shingles)							10/30/2019
High-Dose Fluad					0.5Ml 0.25Ml	LD RD	
Influenza Vaccine Quad - Flucelvax					0.5Ml 0.25Ml	LD RD	08/15/2019
Hep. B							08/15/2019
Hep. A							07/20/2016
Tdap / Td							04/01/2020
Meningitis							08/15/2019

Signature of Administering Pharmacist: _____