IMMUNIZATION SCREENING AND CONSENT FORM

PATIENT INFORMATION *(Please print clearly)*

Last Name:	First Name:	MI:	D.O.B.:	Age:	Gender:
Home Address:				Contact Phone:	
City:		State:		Zip:	
Primary Care Physician:				Physician Phone:	
Physician Address:				Physician Fax #:	

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

☐ Influenza (Injectable)	☐ Hepatitis A & B	☐ Meningococcal	☐ MMR
☐ Influenza (Nasal)	☐ HPV	☐ Td	☐ Varicella
☐ Hepatitis A	☐ Zoster (Shingles)	☐ DTaP	☐ IPV
☐ Hepatitis B	☐ Pneumococcal	☐ Tdap	☐ Hib
☐ Other:			

SCREENING QUESTIONNAIRE

The following questions will help us determine your eligibility to be vaccinated today.

ALL VACCINES	Yes	No	Don't Know
Are you feeling sick or experiencing a moderate to high fever today?			
Do you have any allergies to medications, food (i.e. eggs), latex, vaccine component (e.g. neomycin, formaldehyde, gentamicin, thimerosal, bovine protein, phenol, polymyxin, gelatin, baker's yeast or yeast)? *If yes, please list:*			
Have you ever had a serious reaction to any vaccinations, including fainting and feeling dizzy?			
Have you ever had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder? *If yes, please list:*			
Have you ever had a seizure disorder for which the patient is on seizure medication(s), a brain disorder, Guillain-Barré Syndrome (a condition that causes paralysis) or other nervous system problem?			
For women: Are you pregnant or considering becoming pregnant in the next month?			

LIVE VACCINES (CHICKENPOX, FLU NASAL SPRAY, MMR® II, ORAL TYPHOID, SHINGLES, YELLOW FEVER)	Yes	No	Don't Know
Have you received any vaccinations or skin test within the past four weeks? *If yes, please list:*			
Do you have cancer, leukemia, HIV/AIDS, or any other condition that weakens the immune system?			
During the past year, have you received any transfusion of blood or blood products, or been given a medication called immune (gamma) globulin?			
Do you take cortisone, prednisone, other steroids, anticancer drugs, or have you had any radiation treatments?			

FLU NASAL SPRAY (FLUMIST® QUADRIVALENT)	Yes	No	Don't Know
Are you receiving aspirin therapy or aspirin-containing therapy? (18 years of age and younger only)			
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:	Yes	No	Don't Know
Pneumococcal Vaccine			
Shingles Vaccine			
Tdap (Whooping Cough) Vaccine			

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. 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 NAME: _____
(Please print clearly)

PATIENT SIGNATURE: _____ **DATE:** _____
(Parent or guardian, if minor)

PHARMACY USE ONLY

VACCINE(S) GIVEN

Vaccine	NDC	Manufacturer	Dose	VIS	Lot #	Exp. Date	Site of Administration	Route of Administration
☐ Influenza (Injectable)							☐LA ☐RA	☐IM
☐ Influenza (Nasal)							☐LN ☐RN	☐ NASAL
☐ Hep. A							☐LA ☐RA	☐IM
☐ Hep. B							☐LA ☐RA	☐IM
☐ Hep. A & B							☐LA ☐RA	☐IM
☐ Zoster							☐LA ☐RA	☐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
☐ IPV							☐LA ☐RA	☐IM ☐SQ
☐ Hib							☐LA ☐RA	☐IM
☐ HPV							☐LA ☐RA	☐IM
☐ Other:							☐LA ☐RA ☐LN ☐RN	☐IM ☐SQ ☐ NASAL

PHARMACIST/INTERN SIGNATURE: _____

ADMINISTRATION DATE: _____ **DATE VIS GIVEN TO PATIENT:** _____