Screening Questionnaire and Consent for Immunization

**For Patients:** The following question will help us determine which vaccines you may be given today. If you answer “yes” to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask the provider to explain.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Patient Name: | | | Allergies: | |
| Address: | | City: | State: | Zip: |
| Phone: | DOB: | | Age: | |
| Primary Care Physician: | | | Physician Phone: | |
| Physician Address: | | |  | |
| The following questions are required for our federal reporting (circle one):  Gender Identity: Male/Female/Other\_\_\_\_\_\_\_\_\_\_\_/Decline to state  Race: Caucasian/African American/Hispanic/Other\_\_\_\_\_\_\_\_\_\_\_\_/Decline to state  Smoking Status: Current Smoker/ Previous Smoker/ Never Smoked  Veteran Status: Yes or No  Housing Status: Permanent/Transitional/Homeless/Decline to state | | |  | |

**Vaccine Requested:**

**□ Flu □ Pneumococcal □ Shingles □ Tdap □ Td □ HepA □ HepB □ Meningococcal □ MMR**

|  |  |  |  |
| --- | --- | --- | --- |
| 1. **Vaccination Screen Questionnaire: (Please answer all questions)** | Yes | No | Don’t Know |
| 1. Are you feeling sick today? |  |  |  |
| 1. Do you have allergies to medications, food, a vaccine component or latex?   (EX: eggs, bovine protein, gelatin, gentamicin, polymixin, neomycin, phenol, thimerosal) |  |  |  |
| 1. Have you ever had a serious reaction after receiving a vaccination? |  |  |  |
| 1. Have you had a seizure or a brain or other nervous system problems? |  |  |  |
| 1. Has the person to be vaccinated ever had Guillain-Barré syndrome? |  |  |  |
| 1. Have you received any vaccinations in the past 4 weeks? |  |  |  |
| 1. If you are 65 years of age or older have you ever had a pneumococcal, or “Pneumonia” vaccination? If not applicable please write N/A |  |  |  |
| 1. Is the person to be vaccinated currently pregnant, considering becoming pregnant in the next month, or breast-feeding? |  |  |  |
| 1. Is the person to be vaccinated currently on home infusions, weekly injections, steroid therapy, anticancer drugs, antivirals, radiation treatment, or have a weaken immune system? |  |  |  |
| 1. Do you smoke or have a chronic condition (i.e. asthma, COPD, diabetes)? |  |  |  |

**Patient Consent:**

I have read, or have had read to me, the Vaccination Information Statement (VIS) regarding the vaccine(s) I am about to receive. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccines(s). I consent to, or give consent for, the administration of the vaccines(s) and the notification of my primary care physician. I fully release and discharge their offices, directors and employees from any liability for illness, injury, loss or damage which may result there from. I authorize the release of any medical or other information necessary to process this claim and medical protocol. I also request payment of government benefits either to myself or to the party who accepts assignment. I understand that I should remain in the pharmacy for 15 minutes for observation in case there is an adverse reaction. I understand the purpose/benefits of my state’s immunization registry and acknowledge that I may prevent disclosure of my immunization to the state registry with a signed opt-out.

Patient Name/Legal Guardian/Parent:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_

**(OFFICE USE ONLY**)

Immunizing Pharmacy: NORTH END FAMILY PHARMACY 1517 SAINT JOSEPH AVENUE ST. JOSEPH MO 64505 (816)385-5996

I hereby certify that I have verified the screening questionnaire and consent with the above named patient.

Immunizing Pharmacist Name(print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Pharmacist Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Intern Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Administration Date/Date VIS Given:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Vaccine | NDC | Exp. Date | Lot # | Manufacturer | Dosage | Site(LA/RA) | Route(SQ/IM) | VIS Date | RPH Initials |
|  |  |  |  |  |  | LA RA | SQ IM |  |  |
|  |  |  |  |  |  | LA RA | SQ IM |  |  |
|  |  |  |  |  |  | LA RA | SQ IM |  |  |

□ Standing order physician □Automated reporting □Primary care physician reporting initials:\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_ Time:\_\_\_\_\_\_\_\_\_\_\_\_