The Medicine Shoppe **1304 Mount Rushmore Rd, Rapid City, SD 57701-3667**

Screening Questionnaire and Consent Form for Adult Immunization

For Patients: The following questions 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 your healthcare provider to explain it.

I. Patient Information:

Medicare #: Socal Security #:

Patient Name:		Allergies:	
Address:		City:	State: Zip:
Phone:	DOB:	Age:	Gender: Male ❒ Female ❒
Primary Care Physician:		Mother's Maiden Name:	
Physician Address:		Vaccination requested today?	

II. Vaccination Screening Questionnaire: (Please answer all questions)

		Yes	No	Don't Know
ALL VACCINES	1. Are you feeling sick today?			
	2. Do you have allergies to medications, food, a vaccine component or latex? (Ex: Eggs, bovine protein, gelatin, gentamicin, polymixin neomycin, phenol or thimerosal)			
	3. Have you ever had a serious reaction after receiving a vaccination?			
	4. Have you had a seizure or a brain or other nervous system problems?			
	4A. Has the person to be vaccinated ever had Guillain-Barré syndrome?			
	5. For women: Are you pregnant or is there a chance you could become pregnant during the next month?			
	6. Have you received any vaccinations in the past 4 weeks?			
	7. If over 65 years of age or older OR smoke OR have a chronic condition (i.e. asthma or diabetes), have you ever had a pneumococcal, or "Pneumonia" vaccination?			
LIVE VACCINES	8. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia or other blood disorder?			
	9. Do you have cancer, leukemia, AIDS or any other immune system problem?			
	10. In the past 3 months, have you taken medications that weaken your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs or have you had radiation treatments?			
	11. During the past year, have you received a transfusion of blood or blood products or been given immune (gamma) globulin or an antiviral drug?			
Did you bring your immunization record card with you?				

❖ It is important for you to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.

III. Are your Immunizations up to date? ☐ Yes ☐ No ☐ Unknown

☐Yes ☐No Date _____	Chickenpox	☐Yes ☐No Date _____	Tetanus booster
☐Yes ☐No Date _____	Hepatitis A	☐Yes ☐No Date _____	Meningococcal ACWY
☐Yes ☐No Date _____	IPV (Polio)	☐Yes ☐No Date _____	PPSV 23
☐Yes ☐No Date _____	PCV 13	☐Yes ☐No Date _____	Zoster
☐Yes ☐No Date _____	TDaP(Adults)	☐Yes ☐No Date _____	Haemophilus Influenza B (HIB)
☐Yes ☐No Date _____	TD (Adults)	☐Yes ☐No Date _____	Season Influenza
☐Yes ☐No Date _____	Hepatitis B	☐Yes ☐No Date _____	MMR

Travel Vaccine History

☐Yes ☐No Date _____	Cholera	☐Yes ☐No Date _____	Rabies
☐Yes ☐No Date _____	MENACWY-CRM	☐Yes ☐No Date _____	Japanese Encephalitis
☐Yes ☐No Date _____	Yellow Fever	☐Yes ☐No Date _____	Typhoid Fever
☐Yes ☐No Date _____	Hepatitis A		

❖ A Tetanus booster is needed every 10 years. If you receive a dirty or puncture wound between years 5-10, you may be advised to receive a booster at that time.

IV. Patient Consent:

I have read, or have had read to me, the Vaccination Information Statement (VIS) regarding the vaccines(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 vaccine(s). I consent to, or give consent for, the administration of the vaccine(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. 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.

Patient Name: _____ Patient Signature: _____ Date: _____

V. Recommended Immunizations

Vaccine Administration (Pharmacist Use ONLY)

Vaccine	Dose	Lot#	Exp. Date
Manufacturer	Injection Site/Route Left Right Deltoid IM SQ		
Administered By	VIS Identification	Date of Publication	

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Did an Adverse Reaction occur? ❐ Yes ❐ No

Contacted VAERS 800-822-7967 Date _______ Time ________

Primary Care Physician contacted? ❐ Yes ❐ No

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

_______ **(Initials)**

Pharmacist Signature Date

DID YOU?

- ❐ Answer all of the client's concerns and questions
- ❐ Refer the client to ________________________________ for unavailable immunizations
  List: ____
- ❐ Follow up with a call in 2 weeks for update on receiving immunization
- ❐ Notify the client's PCP of immunization within 72 hours of administration
- ❐ Notify your state's IIS registry of the immunization.

Information for Health Professionals about the Screening Questionnaire for Adults

Are you interested in knowing why we included a certain question on the Screening Questionnaire? If so, read the information below. If you want to find out even more, consult the references listed at the bottom of this page.

1. Are you sick today? *[all vaccines]*
There is no evidence that acute illness reduces vaccine efficacy or increases vaccine adverse events (1). However, as a precaution with moderate or severe acute illness, all vaccines should be delayed until the illness has improved. Mild illnesses (such as upper respiratory infections or diarrhea) are NOT contraindications to vaccination. Do not withhold vaccination if a person is taking antibiotics.

2. Do you have allergies to medications, food, a vaccine component or latex? *[all vaccines]*
History of anaphylactic reaction such as hives (urticaria), wheezing or difficulty breathing, or circulatory collapse or shock (not fainting) to a vaccine component or latex is a contraindication to some vaccines. For example, if a person experiences anaphylaxis after eating eggs, do not administer influenza vaccine, or if a person has anaphylaxis after eating gelatin, do not administer MMR or varicella vaccine. Local reactions are not contraindications. For a table of vaccines supplied in vials or syringes that contain latex, go to www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/latex-table.pdf. For an extensive list of vaccine components, see reference 2.

3. Have you ever had a serious reaction after receiving a vaccination? *[all vaccines]*
History of anaphylactic reaction (see question 2) to a previous dose of vaccine or vaccine component is a contraindication for subsequent doses (1). Under normal circumstances, vaccines are deferred when a precaution is present. However, situations may arise when the benefit outweighs the risk (e.g., during a community pertussis outbreak).

4. Have you had a seizure or a brain or other nervous system problem? *[influenza, Td/Tdap]*
Tdap is contraindicated in people who have a history of encephalopathy within 7 days following DTP/DTaP given before age 7 years. An unstable progressive neurologic problem is a precaution to the use of Tdap. For people with stable neurologic disorders (including seizures) unrelated to vaccination, or for people with a family history of seizure, vaccinate as usual. A history of Guillain-Barré syndrome (GBS) is a consideration with the following: 1) Td/Tdap: if GBS has occurred within 6 weeks of a tetanus-containing vaccine and decision is made to continue vaccination, give Tdap instead of Td if no history of prior Tdap; 2) Influenza vaccine (TIV/LAIV): if GBS has occurred within 6 weeks of a prior influenza vaccine, vaccinate with TIV if at high risk for severe influenza complications.

5. For women: Are you pregnant or is there a chance you could become pregnant during the next month? *[MMR, LAIV, VAR, ZOS]*
Live virus vaccines (e.g., MMR, VAR, ZOS, LAIV) are contraindicated one month before and during pregnancy because of the theoretical risk of virus transmission to the fetus. Sexually active women in their childbearing years who receive live virus vaccines should be instructed to practice careful contraception for one month following receipt of the vaccine. On theoretical grounds, inactivated poliovirus vaccine should not be given during pregnancy; however, it may be given if risk of disease is imminent and immediate protection is needed (e.g., travel to endemic areas). Use of Td or Tdap is not contraindicated in pregnancy. At the provider's discretion, either vaccine may be administered during the 2nd or 3rd trimester. (1, 3, 4, 5, 7, 8)

6. Have you received any vaccinations in the past 4 weeks?
[LAIV, MMR, VAR, yellow fever] If the person to be vaccinated was given either LAIV or an injectable live virus vaccine (e.g., MMR, VAR, ZOS, yellow fever) in the past 4 weeks, they should wait 28 days before receiving another vaccination of this type. Inactivated vaccines may be given at any spacing interval if they are not administered simultaneously.

7. If over 65 years of age or older OR smoke OR have a chronic condition (i.e. asthma or diabetes), have you ever had a pneumococcal, or "Pneumonia" vaccination?
Ask your Pharmacist

8. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder? *[LAIV]*
People with any of these health conditions should not be given the intra-nasal live attenuated influenza vaccine (LAIV). Instead, they should be vaccinated with the injectable influenza vaccine.

9. Do you have cancer, leukemia, AIDS, or any other immune system problem? *[LAIV, MMR, VAR, ZOS]*
Live virus vaccines (e.g., LAIV, measles-mumps-rubella [MMR], varicella [VAR], zoster [ZOS]) are usually contraindicated in immunocompromised people. However, there are exceptions. For example, MMR vaccine is recommended and varicella vaccine should be considered for adults with CD4+ T-lymphocyte counts of greater than or equal to 200 cells/μL. Immunosuppressed people should not receive LAIV. For details, consult the ACIP recommendations (3, 4, 5).

10. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments? *[LAIV, MMR, VAR, ZOS]*

Live virus vaccines (e.g., LAIV, MMR, VAR, ZOS) should be postponed until after chemotherapy or long-term high-dose steroid therapy has ended. For details and length of time to postpone, consult the ACIP statement (1, 5). To find specific vaccination schedules for stem cell transplant (bone marrow transplant) patients, see reference 6. LAIV can be given only to healthy non-pregnant people younger than age 50 years.

11. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? *[LAIV, MMR, VAR]*
Certain live virus vaccines (e.g., LAIV, MMR, VAR) may need to be deferred, depending on several variables. Consult the most current ACIP recommendations for current information on intervals between antiviral drugs, immune globulin or blood product administration and live virus vaccines. (1)

References:

1. CDC. General recommendations on immunization, at www.cdc.gov/vaccines/pubs/acip-list.htm.
2. Table of Vaccine Components: www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/ B/excipient-table-2.pdf.
3. CDC. Measles, mumps, and rubella—vaccine use and strategies for elimination of measles, rubella, and congenital rubella syndrome and control of mumps. *MMWR* 1998; 47 (RR-8).
4. CDC. Prevention of varicella: Recommendations of the Advisory Committee on Immunization Practices. *MMWR* 2007; 56 (RR-4).
5. CDC. Prevention and control of influenza—recommendations of ACIP, at www.cdc.gov/flu/professionals/vaccination.
6. CDC. Excerpt from Guidelines for preventing opportunistic infections among hematopoietic stem cell transplant recipients, *MMWR* 2000; 49 (RR-10), www.cdc.gov/vaccines/pubs/ downloads/b_hsct-recs.pdf.
7. CDC. Notice to readers: Revised ACIP recommendation for avoiding pregnancy after receiving a rubella-containing vaccine. *MMWR* 2001; 50 (49).
8. CDC. Prevention of pertussis, tetanus, and diphtheria among pregnant and postpartum women and their infants: Recommendations of the ACIP. *MMWR* 2008; 57 (RR-4).