☐ No Insurance
☐ Medical Insurance Only
☐ Prescription Insurance Only
☐ Medical and RX Insurance

Colonial Pharmacy

Immunization Questionnaire & Consent Form

Patient Intake Information:

***Patient Name**:_____ ***D.O.B**._____

***Age**:_____ ***Gender**: _____ ☐ Cell ☐ Home ***Phone**: _____ Email: _____

***Race**: ☐ American Indian/Alaska Native ☐ African American/Black ☐ Asian ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other: _____ ***Ethnicity:** ☐ Hispanic/Latino ☐ Not Hispanic/Latino

***Physical Address**:_____ *City:_____*State:_____ *Zip:_____

***Medical Conditions**: _____ *Weight if under 110lbs (for emergency use only): _____

*Primary Physician: _____ ***Physician Phone**: _____

Emergency Contact/Guardian (*required for patients under 18): Name: _____

Phone: _____ Email: _____ Relationship: _____

***Which vaccine(s) would you like to receive today?**

☐ Influenza ☐ Hepatitis A ☐ Hepatitis B ☐ Shingles (Zoster) ☐ Pneumococcal ☐ Tdap ☐ Other: _____

Medical Insurance: (attach copy of card)

***Primary Insurance Provider:** _____ *Insurance Type: ☐ Medicare ☐ Medicaid ☐ TRICARE ☐ CHAMPVA ☐ Other

*ID Number: _____ *Policy Number: _____ *Group Number: _____

*Subscriber/Payer Name: _____ *Relationship: _____

*Gender: _____ *DOB: _____ *Phone Number: _____

***Secondary Insurance Provider:** _____ *Insurance Type:☐ Medicare ☐ Medicaid ☐ TRICARE ☐ CHAMPVA ☐ Other

*ID Number: _____ *Policy Number: _____ *Group Number: _____

*Subscriber/Payer Name: _____ *Relationship: _____

*Gender: _____ *DOB: _____ *Phone Number: _____

Prescription Insurance: (attach copy of card)

*Prescription Insurance Provider: _____ *ID Number: _____

*RX BIN Number: _____ *RX PCN Number: _____ *RX Group Number: _____

The following questions will help us determine which vaccines may be given today. If a question is not clear, please ask your pharmacist to explain it.	Yes	No	Don't Know
Are you sick today? If yes, please circle any of the following you may be experiencing: new fever, cough, diarrhea, vomiting			
Do you have a long term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disorder (e.g. diabetes), anemia or other blood disorders?			
Do you have allergies to medications, food (i.e. eggs), latex or any vaccine component (e.g. neomycin, formaldehyde, gentamicin, thimerosal, bovine protein, phenol, polymyxin, gelatin, baker's yeast or yeast)? **If yes, please list:**			
Have you received any vaccinations in the past 4 weeks?			
Have you ever had a serious reaction after receiving a vaccination, including fainting and feeling dizzy?			
Has a physician or other healthcare provider ever cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a physician's office or hospital?			
Do you take prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?			

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	Yes	No	Don't Know
During the past year, have you received a transfusion of blood or blood products, including antibodies?			
Are you a parent, family member, or caregiver to a newborn infant?			
For children receiving FluMist® Do you receive long term aspirin therapy or have a history of wheezing (2 - 4 years old)?			
For women: Are you pregnant or could you become pregnant in the next three months?			
Did you bring your Immunization Record Card with you?			
Have you had the following vaccines:			
Pneumococcal Vaccine			
Shingles Vaccine			
Whooping Cough (Tdap) Vaccine			

I authorize the pharmacist to send copies of my vaccine documents to my primary care provider. Yes ☐ No☐

Failure to select one of these boxes will result in the vaccine documents being sent to my primary care provider, if known, as state laws & regulations require for my state.

I authorize the release of any medical or other information with respect to this vaccine to my healthcare providers, Medicare, Medicaid or other third party payer as needed and request payment of authorized benefits to be made on my behalf to Colonial Pharmacy.

- I acknowledge that if my insurance does not cover the cost of administering the vaccine at the pharmacy, then payment must be made at the time of the administration of the vaccine.
- I acknowledge that my vaccination record may be shared with federal or state or city agencies for registry reporting.
- I acknowledge that the pharmacist recommends that vaccinated patients should remain in the waiting area for 20 minutes after the administration of the immunization.
- I acknowledge receipt of Colonial Pharmacy's Notice of Privacy Practices for Protected Health Information.
- I have read, or have had read to me the Vaccination Information Sheet (VIS) regarding the vaccine(s). I have had the opportunity to ask questions that were answered to my satisfaction and understand the benefits and risks of the vaccine(s). I consent to, or give consent for, the administration of the vaccine(s). I fully release and discharge Colonial Pharmacy, its affiliates, officers, directors, and employees from any liability for illness, injury, loss, or damage which may result there from.

Patient Signature: _____Date: _____

(If under the age of 18: Legal guardian signature)