Dedham Pharmacy & Medical Supply *781-326-7007* *596 Providence Highway 02026*

SHINGRIX VACCINE (inactivated vaccine)

Screening Questionnaire and Consent Form for Adult Immunization – BY APPOINTMENT ONLY

For Patients: The following questions with help us determine which vaccines 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 you health care provider to explain it.

I. Patient Information

Patient Name:	Address:		
Phone:	DOB:	Age:	Gender: Male ___ Female ___
Allergies:		Medicare #:	
Primary Care Physician:			
Physician Phone:	Physician Address:		

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

	FOR THE PERSON BEING VACCINATED	Yes	No	Don't Know
All Vaccines	1. Are you 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 ever had seizure, or a brain or other nervous system problems?			
	4A. Has the person to be vaccinated ever had Guillain-Barre 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 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?			

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. 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.

Dose #1: Print Name: _____ Patient Signature: _____ Date:_____

Dose #2: Print Name: _____ Patient Signature: _____ Date:_____