Sloan's PHARMACY

IMMUNIZATION SCREENING AND CONSENT FORM

Patient Name:	Date of Birth:	Phone:
Address:	City:	State and Zip Code:

Gender: ☐ Female ☐ Male	Allergies:

Race/Ethnicity: ☐ American Indian/Alaska Native ☐ Black/African American ☐ Hispanic/Latino
☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Asian ☐ Other

Primary Care Doctor:	Dr. Phone #:

Doctor Address:

What vaccine(s) would the patient like to receive today:
☐ Influenza (Injectable) ☐ Zoster (Shingles) ☐ Tdap ☐ Pneumococcal

Other (please list): _____

The following questions will help us determine if you are eligible to be vaccinated today.

1. Are you feeling sick or experiencing a moderate to high fever today?	☐ Yes ☐ No ☐ Don't know
2. Have you ever had an allergic reaction to any vaccinations, including fainting or feeling dizzy?	☐ Yes ☐ No ☐ Don't know
3. Have you ever had a health problem with lung, heart, kidney, or metabolic disease (e.g., diabetes), asthma, or a blood disorder?	☐ Yes ☐ No ☐ Don't know
4. Do you have a long-term health problem with heart, lung, kidney, metabolic disease (e.g., diabetes), asthma, blood disorder, no spleen, complement component deficiency, cochlear implant, spinal fluid leak, or are on a long term-aspirin therapy?	☐ Yes ☐ No ☐ Don't know
5. **For Women**: Are you pregnant or considering becoming pregnant in the next month?	☐ Yes ☐ No ☐ Don't know
6. **For Tdap only**: Do you have an open wound, puncture, or tissue tear that prompted you to get a tetanus shot?	☐ Yes ☐ No ☐ Don't know

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 Sloan's Pharmacy Inc. 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 Statement(s) 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. Additionally, it is recommended to wait for 15 minutes following the vaccination before leaving the premises. 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 Sloan's Pharmacy Inc 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 the people vaccinated at Sloan's Pharmacy Inc, 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 Signature:	Date:
Immunizer Signature:	Administration Date & Date VIS Given to Patient:

Pharmacy Use Only

VACCINE GIVEN:

Vaccine	NDC	Dose	Lot#	Exp. Date	Site of Admin.	Route of Admin.
Influenza (injectable)					**LA RA**	**Intramuscular**
Zoster (Shingles)					**LA RA**	**Intramuscular**
Tdap					**LA RA**	**Intramuscular**
Pneumococcal					**LA RA**	**Intramuscular**
Other						