# Vaccine Screening Questionnaire and Consent Form

Patient Name_____ Date of Birth_____ Gender F M

Address_____ Phone _____

Which vaccines would you like to receive today? ☐COVID-19 ☐Influenza ☐Shingles ☐Tdap ☐Hepatitis A ☐Hepatitis B ☐Meningococcal ☐Pneumococcal

Medicare ID_____ Kancare ID_____

Commercial Insurance Id number_____Bin_____PCN_____Group_____

The following questions will help us determine which vaccines you may be given today. If you answer "yes" to a question, it does not mean you should not be vaccinated. It just means additional questions may be asked. If a question is unclear, please ask the pharmacist to explain it.

| | | Yes | No |
|---|---|---|---|
| 1. | Are you sick today or experiencing a high fever? | ☐ | ☐ |
| 2. | Do you have allergies to medications, polysorbate, vaccine components, or latex? Use an Epipen? | ☐ | ☐ |
| 3. | Have you ever had a serious reaction after receiving a vaccination? | ☐ | ☐ |
| 4. | Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease, anemia, or any bleeding disorder? | ☐ | ☐ |
| 5. | Are you currently taking a blood thinner? | ☐ | ☐ |
| 6. | Do you have cancer, leukemia, HIV/AIDS, or a weakened immune system? | ☐ | ☐ |
| 7. | Have you had a seizure or other nervous system disorder? | ☐ | ☐ |
| 8. | Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as a treatment for COVID-19? | ☐ | ☐ |
| 9. | Have you had a positive test for COVID-19 or has a doctor ever told you that you have COVID-19? | ☐ | ☐ |
| 10. | Have you ever received a dose of COVID-19 vaccine? | ☐ | ☐ |
| 11. | Are you pregnant or breast feeding? | ☐ | ☐ |
| 12. | Have you received any vaccinations in the past 14 days? | ☐ | ☐ |

I have read, or have read to me, the information regarding the vaccine marked above. I have had an opportunity to ask questions that were answered to my satisfaction. I understand the benefits and the risks of the vaccine. I consent to, or give consent for, the administration of the vaccine marked above to:

Form completed by_____ Date_____

Form reviewed by_____ Date_____

VIS/EUA date_____ Manufacturer_____

Site of vaccination L R _____ Lot number_____