I would like:
□ **Flu Shot**
□ **Pneumonia Shot**
□ **Shingles Shot**
□ **Any vaccines I may need**

Custer Pharmacy
"Caring you can count on since 1930"

Patient Consent & Release Form and Screening Questionnaire for Immunization

Section I. Personal Information (Please, print neatly)

Patient's Full Name: _____ **Date of Birth:** _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Home Phone Number: _____ **Cell Phone Number:** _____

Primary Care Doctor: _____

Section II. Questionnaire for Immunization

Please answer these questions by checking the boxes. If the question is not clear, please ask the pharmacist.			**YES**	**NO**	**DON'T KNOW**
ALL	1.	Do you feel sick today?	□	□	□
	2.	Do you have an allergy to medications, foods, or any vaccines? For example: eggs, gelatin, thimerosal, neomycin, gentamicin, or latex	□	□	□
	3.	Have you ever had a reaction or fainted after receiving any vaccination?	□	□	□
	4.	If you are **over the age of 65**, have you ever had a pneumonia vaccination?	□	□	□
	5.	If you are **over the age of 60**, have you ever had a shingles vaccination?	□	□	□
	6.	**For women**: Are you pregnant or are you planning on becoming pregnant?	□	□	□
	7.	**Have you ever had a flu shot before?**	□	□	□
Tdap	8.	Have you ever had a seizure disorder, brain disorder, or Guillain-Barre Syndrome?	□	□	□
LIVE	9.	Have you received any vaccinations in the past 4 weeks? If yes, please specify:	□	□	□
	10.	Do you have cancer, leukemia, HIV, or any long term health condition (such as diabetes, asthma, other)? If yes, please specify:	□	□	□
	11.	Do you take cortisone, prednisone, other steroids, or anti-cancer drugs, or, have you had x-ray treatments recently?	□	□	□
	12.	During the past year, have your received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin?	□	□	□

Section III. Signatures

I understand the benefits and risks of the vaccination(s) as described in the Vaccine Information Statement (VIS), a copy of which was provided with this Consent and Release. I request the vaccine(s) be given to me or to the person named below, a minor for whom I represent that I am authorized to sign this Consent and Release.

Signature of Vaccine Recipient: _____ Date: _____

***I acknowledge that I have received a copy of the appropriate CDC Vaccine Information Statement (VIS).

Pharmacy Use Only:

Vaccine	Manufacturer	Lot Number	Expiration	Admin. Site	RPh/RN Initials
Influenza					
Prevnar 13	Pfizer				
Pneumovax 23	Merck				
Shingrix	GSK				
Boostrix Tdap	GSK				