IMMUNIZATION SCREENING AND CONSENT FORM

PATIENT INFORMATION

First Name | MI | Last Name

Email Address | Phone

Address

City | State | Zip | County

Date of Birth | Age | Gender

Race
- ☐ American Indian/Alaska Native
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ Black/African American
- ☐ White
- ☐ Asian
- ☐ Other
- ☐ Unknown
- ☐ Unable to report due to policy/law

Appointment Date | Appointment Time

Ethnicity
- ◯ Hispanic/Latino
- ◯ Not Hispanic/Latino
- ◯ Unknown
- ◯ Unable to report due to policy/law

INSURANCE INFORMATION

Type of Insurance | Insurance Number | Group Number

Insurance Provider Name | Rx ID | BIN | PCN

PRIMARY CARE PHYSICIAN INFORMATION

Physician's Full Name | Physician's Phone | City

REQUESTED VACCINES

Which vaccine(s) would the patient like to receive today?

- ☐ Influenza (Injectable)
- ☐ Influenza (Nasal)
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis A & B
- ☐ HPV
- ☐ Zoster (Shingles)
- ☐ Pneumococcal
- ☐ Meningococcal
- ☐ Td
- ☐ DTaP
- ☐ Tdap
- ☐ MMR
- ☐ Varicella
- ☐ IPV
- ☐ Hib

Fax Completed Form to (601) 544-4707 or email to pdci1@aol.com with "vaccine form" in the subject.

SCREENING QUESTIONS

		Yes	No	Don't Know
ALL VACCINES				
1.	**Are you feeling sick or experiencing a moderate to high fever today? If yes, please list:**	☐	☐	☐
2.	**Have you ever had a serious reaction to any vaccinations, including fainting and feeling dizzy?**	☐	☐	☐
3.	**Have you ever had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder? If yes, please list:**	☐	☐	☐
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?**	☐	☐	☐
5.	**For Women: Are you pregnant or considering becoming pregnant in the next month?**	☐	☐	☐
6.	**For Tdap or adult Td only: Do you have an open wound, puncture or tissue tear that prompted you to get a tetanus shot?**	☐	☐	☐
LIVE VACCINES (Chickenpox, Flu Nasal Spray, MMR® II, Oral Typhoid, Yellow Fever)				
7.	**Have you received any vaccinations or skin test within the past four weeks? If yes, please list:**	☐	☐	☐
8.	**Do you have cancer, leukemia, HIV/AIDS, or any other condition that weakens the immune system?**	☐	☐	☐
9.	**During the past year, have you received any transfusion of blood or blood products, or been given a medication called immune (gamma) globulin?**	☐	☐	☐
10.	**In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?**	☐	☐	☐
FLU NASAL SPRAY (Flumist®, Quadrivalent)				
11.	**(18 years of age and younger) Are you receiving aspirin therapy or aspirin-containing therapy?**	☐	☐	☐
12.	**(For FluMist® only) Do you have a nasal condition serious enough to make breathing difficult, such as a very stuffy nose**	☐	☐	☐
HAS THE PATIENT HAD THE FOLLOWING VACCINES				
13.	**Pneumococcal Vaccine**	☐	☐	☐
14.	**Shingles Vaccine**	☐	☐	☐
15.	**Tdap (Whooping Cough) Vaccine**	☐	☐	☐

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 "_____", 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 "_____" 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 people vaccinated at "_____" 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 First Name

Patient Last Name

Patient Signature (Parent or guardian, if minor)

Date

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PHARMACY USE ONLY

VACCINE(S) GIVEN

Vaccine	NDC	Manufacturer	Dose	VIS Date	Lot #	Exp Date	Site of Admin	Route of Admin
☐ Influenza (Injectable)							☐ LA ☐ RA	☐ IM
☐ Influenza (Nasal)							☐ LN ☐ RN	☐ Nasal
☐ Hepatitis A							☐ LA ☐ RA	☐ IM
☐ Hepatitis B							☐ LA ☐ RA	☐ IM
☐ Hepatitis A & B							☐ LA ☐ RA	☐ IM
☐ Zoster (Shingles)							☐ LA ☐ RA	☐ IM ☐ SQ
☐ Pneumococcal							☐ LA ☐ RA	☐ IM ☐ SQ
☐ Meningococcal							☐ LA ☐ RA	☐ IM ☐ SQ
☐ Td							☐ LA ☐ RA	☐ IM
☐ Tdap							☐ LA ☐ RA	☐ IM
☐ MMR							☐ LA ☐ RA	☐ SQ
☐ DTaP							☐ LA ☐ RA	☐ IM
☐ Varicella							☐ LA ☐ RA	☐ SQ
☐ IPV							☐ LA ☐ RA	☐ IM ☐ SQ
☐ Hib							☐ LA ☐ RA	☐ IM
☐ HPV							☐ LA ☐ RA	☐ IM
☐ Other							☐ LA ☐ RA ☐ LN ☐ RN	☐ IM ☐ SQ ☐ Nasal

Administered by (Signature)

Supervising Pharmacist Signature (If applicable)

Date VIS Given to Patient

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