VACCINE QUESTIONAIRE/CONSENT

Patient Name: _____ Gender: _____ DOB: _____

Address: _____ Phone No:_____

Insurance Info: _____

VACCINE SCREENING QUESTIONNAIRE

1.	Are you sick today?	**Yes**	**No**	**Don't know**
2.	Do you have allergies to medications, food, eggs, latex or any vaccine?	**Yes**	**No**	**Don't know**
3.	Have you ever had a serious reaction after receiving a vaccination?	**Yes**	**No**	**Don't know**
4.	Do you have cancer, leukemia, AIDS, or any other immune system problem?	**Yes**	**No**	**Don't know**
5.	Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had X-ray treatments?	**Yes**	**No**	**Don't know**
6.	During the past year, have you received a transfusion of blood or blood products, including antibodies?	**Yes**	**No**	**Don't know**
7.	Have you received any vaccinations in the past 4 weeks?	**Yes**	**No**	**Don't know**
8.	Do you have a neurological disorder such as seizures or other disorders that affect the brain or have a neurological disorder that resulted from a vaccine?	**Yes**	**No**	**Don't know**
9.	Are you pregnant or is there a chance you could become pregnant in the next three months?			

ONLY ANSWER THESE QUESTIONS IF YOU ARE GETTING THE COVID-19 VACCINE

In the last 10 days, have you had a COVID-19 test because you had symptoms and are still awaiting your test results or been told by a health care provider or health department to isolate or quarantine at home due to COVID-19 infection or exposur**e** **Yes** **No** **Don't know**

Has the person to be vaccinated ever received a dose of COVID-19 vaccine? **Yes** **No** **Don't know**

- **If yes, which product was administered?**

□ Pfizer-BioTech □ Janssen (Johnson & Johnson) □ Moderna □ Novavax □ Another product

- How many doses of COVID-19 vaccine were previously administered? _____

- Did you bring the vaccination record card or other documentation? **Yes** **No** **Don't know**

Vaccination Consent: I have received the Vaccine Information Statement(s), the content was explained to me before vaccine administration, and I give consent to, or give consent for, administration of the vaccination(s). I have had a chance to ask questions which were answered to my satisfaction and I understand the benefits and risks of the vaccination(s). I request that the vaccination(s) be given to me (or the person named above for whom I am authorized to make this request). I acknowledge that I received a detailed copy of the Notice of Privacy Practices (either in the past or today) to help me better understand Country Chemists, Inc. policies regarding the use of my personal health information. I authorize the release of any medical or other information necessary to process Medicare or other insurance claim or for public health purposes. **I agree to and acknowledge that the pharmacist has recommended that I remain in the waiting are for 15 minutes.** I fully release and discharge Country Chemists/Medford Chemists Inc.., its affiliates, directors, and employees from any liability for illness, injury, loss, or damage which may result. I further agree that while this immunization is being billed by Medford Chemists Inc. that I am financially responsible for any copy or co-sharing amount no covered by my insurance at the time of service.

_____ _____ _____

Printed Name of recipient (or guardian) Signature of recipient (or guardian) Date

AREA BELOW TO BE COMPLETED BY IMMUNIZING PHARMACIST

Influenza Vaccine

Manufacturer: _____

Lot No/Exp Date: _____

VIS Date: _____ Date Given:_____

Dose: ☐ 0.2ml Nasal ☐ 0.1ml Intradermal ☐ 0.5ml IIV, high-dose IIV, or RIV IM

Site: ☐ Left ☐ Right Deltoid

Other: _____ Vaccine

Manufacturer: _____

Lot No/Exp Date: _____

VIS Date: _____ Date Given:_____

Dose/Site: ☐ 0.65ml SQ

Site: ☐ Left ☐ Right Arm

Covid -Moderna

Manufacturer:_____

Lot No/Exp Date: _____

VIS Date: _____ Date Given:_____

Dose: ☐ 0.2ml/10ug pink/yellow ☐ 0.25ml/25ug blue/gray ☐ 0.5ml/50ug blue/gray

Site: ☐ Left ☐ Right Arm

Signature of RPH who administered vaccine(s):_____ Lic#_____