Immunization Screening Form

Providence Community Pharmacy

First Name: _____Last Name: _____ Date of Birth: _____ Age: _____

Gender: ◯ Female ◯ Male Home Phone: _____Cell Phone: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Primary Care Physician: _____ Phone Number: _____

Medicare Part B Number (if applicable): _____

I want to receive the following immunization(s):

◯ Inactivated Influenza (Flu) ◯Pneumonia ◯Shingles ◯Tdap (Whooping Cough) ◯Other: _____

Please answer the following questions to help us decide if you can get a vaccination today:	YES	NO	Don't Know
Are you currently sick with a moderate to high fever, vomiting/diarrhea?	☐	☐	☐
Have you ever fainted or felt dizzy when receiving an immunization?	☐	☐	☐
Have you ever had a serious reaction after receiving an immunization?	☐	☐	☐
Do you have allergies to medications, food, or vaccines? (examples: eggs, bovine protein, gelatin, gentamycin, polymyxin, neomycin, phenol, yeast, or thimerosal) **If yes, please list:**	☐	☐	☐
Have you received any vaccinations or skin tests in the past four weeks? **If yes, please list:**	☐	☐	☐
Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-Barre syndrome, or other nervous system problem?	☐	☐	☐
Are you 65 years of age or older?	☐	☐	☐
Do you smoke, use e-cigarettes, or vape?	☐	☐	☐
Do you have a chronic condition or long-term health problem? If yes, please check all that apply: ◯Anemia ◯Asthma ◯Diabetes ◯Heart Disease ◯Liver Disease ◯Lung Disease ◯Other:	☐	☐	☐
Have you ever had a pneumonia vaccination?	☐	☐	☐
For women: Is there a chance you could be pregnant or are you considering becoming pregnant in the next month?	☐	☐	☐
For people who are getting live vaccines like Nasal Flu:	☐	☐	☐
Are you currently on home infusions, weekly injections, steroid therapy, anticancer drugs, or radiation treatments?	☐	☐	☐
Do you have cancer, leukemia, lymphoma, HIV/AIDS or any other immune system disorder or are you in contact with anyone who has a severely weakened immune system?	☐	☐	☐
Have you received a transfusion of blood or blood products, or have you been given a medicine called immune (gamma) globulin in the past year?	☐	☐	☐
Are you currently taking high-dose steroid therapy (prednisone > 20mg/day) for longer than two weeks?	☐	☐	☐
Questions? Do you have any questions you would like to ask the pharmacist?	☐	☐	☐

Continued on the back

- I give permission to the Providence Community Pharmacy pharmacist or the intern to give me the vaccines(s) I have check marked.
- I understand the risks and benefits associated with the vaccines(s) I am getting. I have received, read and/or had explained to me the Vaccine Information Statements on the vaccine(s) I am getting. I have had a chance to ask questions and I understand the answers.
- I understand that it is not possible to predict all the possible side effects or complications associated with the vaccine(s) I am getting.
- I will stay at Providence Community Pharmacy for 15 minutes after the vaccination so they can give me care in case I have a reaction from the vaccine.
- I give permission for Providence Community Pharmacy to give information to Medicare, Medicaid, or any other insurance I have to help pay my bill. I allow Medicare, Medicaid and any other insurance I have to pay Providence Community Pharmacy. I know that I will have to pay any bills that Medicare, Medicaid or my other insurances do not pay.

_____ _____

Signature of Patient or legal representative Date

_____

Relationship