IMMUNIZATION SCREENING AND CONSENT FORM

PATIENT INFORMATION ***(Please print clearly)***

Patient's Full Name (First, MI, Last): _____

Date of Birth: _____ Age: _____ Gender: ___M ___F Phone number: _____

Address: _____City: _____ State: _____ Zip Code: _____

Primary Care Doctor: _____ Mother's First & Maiden Name: _____

(For NC Immunization Registry)

I want to receive the following vaccine(s) today: _____

SCREENING QUESTIONNAIRE

Please answer the questions by checking the boxes.	**Yes**	**No**	**I don't know**
Are you feeling sick or experiencing a moderate to high fever today?			
Do you have an allergy to medications, foods, yeast, any vaccines, or Latex? (If **YES**, please specify)			
Have you ever had a serious reaction to any vaccinations, including fainting and feeling dizzy?			
Have you been diagnosed with: lung disease, asthma, chronic cardiovascular disease, diabetes, HIV/AIDS, cancer, kidney disease, liver disease, anemia, other blood disorder?			
Have you ever had a seizure disorder, brain disorder, Guillain-Barre Syndrome, or other nervous system problem?			
In the past 3 months have you taken medications that weaken your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs and radiation treatments? If yes, please specify:			
During the past year, have you received a blood transfusion, or been given an antiviral or immune globulin drug?			
In the past 4 weeks have you received any vaccinations or a TB skin test?			
For women: Are you pregnant or is there a chance you could become pregnant during the next month?			
For Tdap: Do you have a cut, injury, puncture or open wound that prompted you to get a tetanus shot?			

Have you received the following vaccines:	Yes	No	I don't know
Pneumonia Vaccine			
Shingles Vaccine			
Tdap Vaccine			

Signature for Consent

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. I request the vaccine(s) be given to me or to the person named above, a minor for whom I represent that I am authorized to sign this Consent. I request that payment of authorized Medicare/Medicaid/and/or private insurance benefits for immunizations listed below be made on my behalf to Carter's Family Pharmacy.

Signature of Person to Receive Vaccine (or Parent/Guardian, if Recipient is a Minor): _____

Print Guardian name and phone # (if Recipient is a Minor): _____ **Date:** _____

_____**(Pharmacy Use Only)**_____

Vaccine	**Date Administered**	**Vaccine Lot #**	**Exp Date**	**MFR**	**Dosage**	**Inj Site**	**Pharmacist's Signature/Date**
AFLURIA		P100464789	05/30/2023	Sanofi	0.5 ml		
Pneumovax/Prevnar				Merck	0.5 ml		
Shingrix				GSK	0.5 ml		
T-dap				GSK	0.5 ml		
Fluad(HD)		346349	04/29/2023	Seqirus	0.5 ml		