

# 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 <b>YES</b> , 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?			
<b>For women:</b> Are you pregnant or is there a chance you could become pregnant during the next month?			
<b>For Tdap:</b> 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
Fluzone		UJ452AB	6/30/21	Sanofi	0.5 ml		
Pneumovax/Prevnar				Merck	0.5 ml		
Shingrix				GSK	0.5 ml		
T-dap				GSK	0.5 ml		
Fluad(HD)		279781	5/12/21	Seqirus	0.5 ml		