ELKTON FAMILY PHARMACY

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IMMUNIZATION PATIENT HISTORY, SCREENING, AND CONSENT FORM

Patient Name: _____ DOB: ____/____/_____ Gender M F

Home Address: _____ City: _____ ST: ___ ZIP: _____

Daytime Telephone: (___) _____-_____

Primary Care Physician/Provider: _____

Medical Conditions (check those that apply):

- ☐ Asthma
- ☐ Cancer
- ☐ Chronic Bronchitis
- ☐ Cirrhosis of the Liver
- ☐ COPD
- ☐ Congestive Heart Failure
- ☐ Diabetes Mellitus
- ☐ Emphysema
- ☐ Hemodialysis
- ☐ Heart Disease
- ☐ HIV Infection
- ☐ Immune Deficiency
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Multiple Myeloma
- ☐ Organ Transplant
- ☐ Splenectomy/ Inactive Spleen
- ☐ Sickle Cell Disease
- ☐ Terminal Complement Component Deficiency
- ☐ Tuberculosis (untreated)
- ☐ History of Shingles

Comments: _____

List Current Medications (or refer to current drug profile)

_____ _____

_____ _____

Take time to answer the following questions, these questions will help us determine which vaccines may be given to you today. Please check the appropriate answer. If any question is not clear, please ask us to explain it. Discuss any major medical condition(s) you may have with our pharmacist and talk with our pharmacist administering your shot, if you have any questions.

	Yes	No	Unsure
Do you feel sick or ill today or do you currently have a fever or infection? **If yes, please explain:**			
Do you have allergies to latex, medications, food or vaccines? (Examples: eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal) **If yes, please explain:**			
Have you ever had a serious reaction after receiving a vaccination? **If yes, please explain:**			
Do you have an immune-compromising condition (e.g., cancer, leukemia, lymphoma, HIV/AIDS, transplant), functional, or anatomic asplenia, CSF leak or cochlear implant?			
Are you currently on home infusions, weekly injections, steroid therapy, anticancer drugs, or radiation treatments?			
Have you received a transfusion of blood, blood products or been given a medication called immune (gamma) globulin in the past year?			
For women: Is it possible that you are pregnant today or may become pregnant in the month?			
Have you received any vaccinations or skin tests in the past four weeks? **If yes, please explain:**			
Have you ever had a shingles vaccination (for patients 50 years of age and older)			
Are you a healthcare worker?			
Have you ever had a pneumonia vaccination?			

CONSENT FOR ADMINISTRATION OF VACCINE

☐ Flu Shot
☐ Hepatitis A
☐ Hepatitis B
☐ Gardasil
☐ Measles, Mumps, Rubella
☐ Meningococcal
☐ Pneumonia –Prevnar 13
☐ Pneumonia – Pneumovax 23
☐ Tdap (tetanus, diphtheria, and pertussis)
☐ Shingrix
☐ Varicella
☐ _____

I certify that I am at least 18 years old and hereby give my consent to the staff of Elkton Pharmacy to administer the vaccine(s) discussed and noted below. I understand that it is not possible to predict all possible side effects or complications associated with vaccines. I understand possible risks associated with influenza and / or pneumococcal vaccines may include but are not limited to: ~pain and redness at injection site, headache, fever, paralysis, muscle pain, nerve pain, Gullain-Barre Syndrome, encephalitis, or allergic reactions (including anaphylactic shock or death). I, on behalf of myself, my heirs, executors, personal representatives, agents, successors and assigns hereby agree to release indemnify and hold harmless Elkton Pharmacy and employees from any and all claims arising out of, in connection with, or in any way related to the administration of the vaccines listed below. I agree to wait near the vaccination location for approximately 15 minutes for observation if needed.

_____ _____

PRINTED Name Signature

A record of immunizations received will be maintained at the pharmacy, and a copy will be provided to you.

The following section is to be completed by our staff				
	Vaccine	**Lot**	**Expiration**	**Site of Injection**
	Afluria			IM Deltoid R / L
	Fluzone HD			IM Deltoid R / L
	Flucelvax			IM Deltoid R / L
				IM Deltoid R / L
				IM Deltoid R / L
	Shingrix			IM Deltoid R / L
	Prevnar – 13			IM Deltoid R / L
	Pneumovax-23			IM Deltoid R / L

COVID-19 Questions (to be asked and answered at time of vaccination):

1. Do you have a fever or above-normal temperature (>100.4 F)?
   Yes ☐ **No** ☐
2. Are you experiencing shortness of breath or having trouble breathing? **Yes** ☐ **No** ☐
3. Do you have a dry cough?
   Yes ☐ **No** ☐
4. Even if you don't currently have any of the above symptoms, have you experienced any of these symptoms in the last 14 days? **Yes** ☐ **No** ☐
5. Have you been in contact with someone who has tested positive for COVID-19 in the last 14 days?
   Yes ☐ **No** ☐
6. Have you traveled more than 100 miles from your home in the last 14 days?
   Yes ☐ **No** ☐

Immunizer:	**Date of Vaccination**
☐ Angela Brittle, R.Ph.	
☐ Brian Nelson, R.Ph.	
☐ Brooks Tune, PharmD	
☐	

VIS Version given _____