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
- ☐ Other _____

Any known medication allergies ☐ *No* ☐ *Yes* (please list)_____

Take time to answer the following questions, these questions will help us determine which vaccines may be given to you today. 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, diarrhea, vomiting, 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:			
Have you ever had an allergic reaction to a component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures?			
Have you ever had an allergic reaction to Polysorbate, which is found in some vaccines, film-coated tablets and intravenous steroids?			
Have you ever had an allergic reaction to a previous dose of COVID-19 Vaccine?			
Have you ever had a positive test for COVID-19 or has a health care provider ever told you that you had COVID-19 within the past two weeks?			
Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? If yes, when did you receive antibody therapy:_____			
Do you have a bleeding disorder or are you taking a blood thinner?			
Do you have dermal fillers?			
Do you have a history of myocarditis or pericarditis?			
Do you have a history of heparin-induced thrombocytopenia?			
Do you have a history of Guillain-Barre Syndrome (GBS)?			
Have you been diagnosed with Multisystem Inflammatory Syndrome after a COVID-19 infection?			
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 3 months?			
Have you received any vaccinations or skin tests in the past 14 days? 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?			

List Current Medications (or refer to current drug profile) _____

_____

_____

Please select which vaccine you wish to receive today:

- ☐ **Flu Shot**
- ☐ **High Dose Flu Shot**
- ☐ **Covid-19 2024-25**
- ☐ **Abrysvo (RSV vaccine)**
- ☐ **Meningococcal**
- ☐ **Hep A/Hep B**
- ☐ **Pneumonia – Prevnar 20**
- ☐ **Pneumonia- Pneumovax 23**
- ☐ **Shingrix**
- ☐ **TDAP**
- ☐ **_____**

I understand the benefits and risks of the COVID-19 vaccine as described in the Fact Sheet, which I was provided with this Consent Form. I have had a chance to ask questions that were answered to my satisfaction. If INSURED, by signing below I attest I will bring in **prescription insurance cards** for your vaccine appointment. By signing this, you are also authorizing the pharmacy to bill your insurance on your behalf for the immunization.

I certify that I am at least 18 years old and hereby give my consent to the staff of Elkton Family 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 immunizations may include but are not limited to pain and redness at injection site, headache, fever, paralysis, muscle pain, nerve pain, Guillain-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 Family 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.

By signing below I attest that it has been at least TWO MONTHS since my last COVID vaccine if applicable

_____ _____

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				
Date	**Vaccine**	**Lot**	**Expiration**	**Site of Injection**
	Afluria MDV 24-25			IM Deltoid R / L
	Afluria PFS 24-25			IM Deltoid R / L
	Fluad HD PFS 24-25			IM Deltoid R / L
	Abrysvo			IM Deltoid R / L
	Shingrix			IM Deltoid R / L
	Boostrix			IM Deltoid R / L
	Moderna 2024-25			IM Deltoid R / L
	Pfizer 2024-25			

Name of person administering:_____ Signature of Pharmacist:_____