ST JESUS PHARMACY CORP

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Vaccine Screening Questionnaire, Consent & Physician Fax Form

Patient's Information

Patient's Name: _____ **Date of Birth:**_____ **Age:** ____

Address: Street: _____ **City:** _____ **State:** ____ **Zip:** _____

Phone Number:_____ **Email:**_____

Gender: □ Male
□ Female
□ Non-Binary
□ Other_____

Ethnicity: □ Hispanic or Latino
□ Not Hispanic or Latino
□ Unknown
□ Decline to Answer

Race: □ African American / Black
□ Asian
□ Native American
□ Native Hawaiian or Pacific Islander
□ White
□ Other or Multiracial

Which Vaccine are you requesting to have administered?

□ COVID
□ Influenza(Flu)
□ Pneumonia
□ Shingles
□ Tetanus/Diphtheria/Pertussis
□ RSV
□ Meningitis

Primary Doctor: _____ Doctor's Phone # _____

The following questions will help us to determine which vaccines may be given today. If question in not clear, please ask the immunizer or pharmacy staff to explain it.

	Yes	No	Don't Know
1. Do you feel sick today?			
2. Do you have any allergies – If yes, please list and include any food, medication, and vaccine allergies (examples: egg, latex, chicken, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast, thimerosal or latex)_____			
3. Have you ever had a serious reaction to a vaccine, such as dizziness, fainting, or seizures?			
4. Have you received any vaccination or skin tests in the past 4 weeks?			
5. Do you smoke?			
6 Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-Barré syndrome (a condition that causes paralysis) or other nervous system problem.			
7. Do you have any health conditions such as anemia, asthma, diabetes, heart disease, kidney disease, liver disease, lung disease or other? Please list:			
8. For Women: Are you pregnant or is there a chance you could become pregnant in the next 3 months?			
9. Are you currently on home infusions, weekly injections, steroid therapy, anticancer drugs or radiation treatments?			
10. Do you have cancer, leukemia, lymphoma, HIV/AID or any other immune system disorder or are you in contact with anyone who has a severely weakened immune system?			
11. Have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin in the past year?			

PHARMACY USE ONLY:

Vaccine	Manufacturer	Lot#	Exp Date	Dosage	Circle Inj Site	VIS Date
					L / R Deltoid IM	
					L / R Deltoid IM	

Immunizer Signature & gave VIS: _____Date Vaccine administered & VIS given: _____

Immunizer Name/Title: _____

- Acknowledgement: I certify that I am: (a) the patient and at least 18 years of age; (b) the parent or legal guardian of the minor patient; or (c) the legal guardian of the patient. Further, I hereby give my consent to the pharmacy and the licensed healthcare professional administering the vaccine, as applicable (each an "applicable Provider"), to administer the vaccine(s) I have requested above. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine(s) and have received, read and/or had explained to me the Vaccine Information Statements on the vaccine(s) I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. Further, I acknowledge that I have been advised to remain near the vaccination location for observation for approximately 15 minutes after administration. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless St Jesus Pharmacy Corp, each applicable Provider, its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above. I acknowledge that: (a) I understand the purposes/benefits of my state's vaccination registry ("State Registry") and my state's health information exchange CIR ("State HIE"); and (b) the applicable Provider may disclose my vaccination information to the State Registry, to the State HIE, or through the State HIE to the State Registry, for purposes of public health reporting, or to my healthcare providers enrolled in the State Registry and/or State HIE for purposes of care coordination. I acknowledge that, depending upon my state's law, I may prevent, by using a state-approved opt-out form or, as permitted by my state law, an opt-out form ("Opt-Out Form") furnished by the applicable Provider: (a) the disclosure of my vaccination information by the applicable Provider to the State HIE and/or State Registry; or (b) the State HIE and/or State Registry from sharing my vaccination information with any of my other healthcare providers enrolled in the State Registry and/or State HIE. The applicable Provider will, if my state permits, provide me with an Opt-Out Form. I understand that, depending on my state's law, I may need to specifically consent, and, to the extent required by my state's law, by signing below, I hereby do consent to the applicable Provider reporting my vaccination information to the State HIE, or through the State HIE and/or State Registry to the entities and for the purposes described in this Informed Consent form. Unless I provide the applicable Provider with a signed Opt-Out Form, I understand that my consent will remain in effect until I withdraw my permission and that I may withdraw my consent by providing a completed Opt-Out Form to the applicable Provider and/or my State HIE, as applicable. I understand that even if I do not consent or if I withdraw my consent, my state's laws may permit certain disclosures of my vaccination information to or through the State HIE as required or permitted by law. I also authorize the applicable Provider to disclose my, or my child's (or unemancipated minor for whom I am authorized to act as guardian or in loco parentis), proof of vaccination to the school where I am, or my child (or unemancipated minor for whom I am authorized to act as guardian or in loco parentis) is, a student or prospective student. I further authorize the applicable Provider to: (a) release my medical or other information, including my communicable disease (including HIV), mental health and drug/alcohol abuse information, to, or through, the State HIE to my healthcare professionals, Medicare, Medicaid, or other third-party payer as necessary to effectuate care or payment; (b) submit a claim to my insurer for the above requested items and services; and (c) request payment of authorized benefits be made on my behalf to the applicable Provider with respect to the above requested items and services. I further agree to be fully financially responsible for any cost-sharing amounts, including copays, coinsurance and deductibles, for the requested items and services, as well as for any requested items and services not covered by my insurance benefits. I understand that any payment for which I am financially responsible is due at the time of service or, if the applicable Provider invoices me after the time of service, upon receipt of such invoice.

Patient's Signature: _____ **Date:** _____