Bob Johnson's Pharmacy
1407 NW 85th St Seattle, WA 98117-4237
Immunization Screening and Informed Consent

First Name: _____ **Last Name**: _____**Birthdate**: _____ **Age**: _____

If a minor, name of parent/guardian:_____

Address: _____**City/State/ Zip**_____

Gender_____ **Phone Number**: _____

Primary Care Provider:_____ **PCP Phone**:_____

Race:

□American Indian/Alaskan Native
□ Asian
□ Black/African American
□ White
□ Native Hawaiian/Other Pacific Islander
□ Other

Ethnicity:

□ Hispanic/Latino
□ Not Hispanic/Latino
□ Decline

Vaccine(s) Requested: _____

Please read the list below and indicate YES or NO for the person receiving the vaccine today.

Has the person ever had a severe reaction to any vaccine which has required medical care?	YES NO
Is this person allergic to eggs, chicken, baker's yeast, latex, gelatin, streptomycin or neomycin?	YES NO
Does this person have a fever, diarrhea, or vomiting today?	YES NO
Does this person have long-term lung (i.e. asthma), heart, kidney, metabolic (i.e. diabetes) or a blood disorder? (LAIV)	YES NO
Does this person or anyone in the home have cancer, leukemia HIV/AIDS or any immune disorder? Live	YES NO
Has this person or anyone in the home taken medications that weaken the immune system in the last 3 months, such as cortisone, prednisone, other steroids, chemotherapy, or radiation? Live	YES NO
Has this person had a seizure, Guillain-Barre syndrome, or other brain or nervous system problem? Flu/Td/Tdap lids-DTap,Td,Tdap,TIV, LAIv, MMRV0	YES NO
If this person is a child, has a sibling or parent ever had a seizure?	YES NO N/A
Has this person received an antiviral drug, immune globulin or a blood transfusion in the past 12 months	YES NO
Is this person pregnant or planning pregnancy in the next month? Live	YES NO
Has this person received a live vaccine in the last 28 days? Live	YES NO
If this person is a child between ages 2 and 4, has a healthcare provider told you the child has wheezing or asthma in the past 12 months? (LAIV)	YES NO N/A
If this person is a baby, have you been told s/he has intussusception? (Rotavirus)	YES NO N/A

Note: Record of this vaccination will be available to your physician on the Washington State Immunization Information System site.

Please list any prescription or over-the-counter medications this person is currently taking:

_____

_____

I have read, or have had explained to me, information about the vaccine(s) listed below. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccines cited and ask the vaccine(s) below be given to me or to the person named above (for whom I am authorized to make this request). I understand that it is recommended I stay on location for 15 minutes following the immunization.

Signature: _____ **Date**: _____

Pharmacy Use Only

Rx label

Hard copy label

Vaccinator initials: ____

Anatomical site: _____

VIS date: _____

_____ _____

Prescriber signature Date