Bob Johnson's Pharmacy

1407 NW 85th St Seattle, WA 98117-4237
P: (206)782-5822 F: (206)781-0379

Immunization Screening and Informed Consent

Name_______________________________ Date of Birth_______________ Date____________

Address__________________________ City________________ State______ Zip____________

□ Male □ Female Phone Number (Primary)____________________(Secondary)____________________

Primary Care Provider________________________________ PCP Phone____________________

Which vaccine(s) are you interested in receiving today? ______________________________

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………………………………………

Vaccinator initials _____
Anatomical site _______

VIS date ___________

Rx label

Prescriber signature

Date