Medicine Shoppe Pharmacy Immunization Consent Form & Screening Questionnaire

Section I. Personal information (Please print neatly.)

Patient's Full Name (First, MI, Last:)_____ **Date of Birth:**_____

Age:_____ **Gender:**___**M** ___**F** **List Medical Conditions:**_____

Address:_____ **City:**_____ **State:**_____ **Zip Code:**_____

Phone Number:_____ **Emergency Contact and Number:**_____

Primary Doctor:_____ **Primary Insurance:**_____ **Cardholder Name:**_____

Insurance# / Medicare ID#:_____

REQUESTED VACCINES:

☐ **Influenza** ☐ **RSV** ☐ **Tdap** ☐ **Shingles** ☐ **Pneumococcal** ☐ **Covid**

Section II: Questionnaire for Immunization

		Please answer these questions by checking the boxes. If the question is not clear, please ask the pharmacist.	**Yes**	**No**	**Don't Know**
ALL	1.	Do you feel sick today?	☐	☐	☐
	2.	Do you have an **allergy** to medications, foods or any vaccines? For Example: Eggs, Gelatin, Thimerosal, Neomycin, Gentamicin, or Latex	☐	☐	☐
	3.	Have you ever had a reaction or fainted after receiving any vaccination?	☐	☐	☐
	4.	**If you are over the age of 65:** Have you ever had a Pneumococcal vaccination?	☐	☐	☐
	5.	**If you are over the age of 50:** Have you ever had a Shingles vaccination?	☐	☐	☐
	6.	**For women:** Are you pregnant or are you planning on becoming pregnant?	☐	☐	☐
	7.	Do you take any of the following "TNF Blockers" for the treatment of rheumatoid arthritis: etanercept (Enbrel), rituximab, adalimumab (Humira), or infliximab?	☐	☐	☐
	8.	Have you ever had Guillain-Barre Syndrome?	☐	☐	☐

Section III. Influenza Information. <u>For other vaccines, (i.e. Pneumococcal, Shingles, Tdap), refer patient to the appropricate VIS</u>

Inactivated Influenza Vaccine (injection) <u>ages 6-months old and older:</u> Created from a dead virus, the flu vaccine will not give you the flu. Injection is in the muscle. Some vaccines contain a preservative called thimerosal; thimerosal-free vaccines are available upon request. **Side effects** include soreness, redness, or swelling at the injection site. Fever, hoarseness, red or itchy eyes, fatigue, and muscle aches are also possible. These symptoms usually begin soon after the shot and last for one to two days.

Live, Attenuated Influenza Vaccine (nasal spray) <u>ages 2-49</u>: Live but attenuated (weakened) virus that is sprayed into the nostrils. **Side effects** in children (ages 2-17 years of age) include runny nose, nasal congestion, cough, fever, wheezing, headache, muscle ache, and abdominal pain/occasional vomiting/diarrhea. Side effects are generally mild in adults and occur at low frequency. **Side effects** in adults (18-49 years of age) include runny nose/nasal congestion, cough, chills, tiredness/weakness, sore throat, and headache. These symptoms usually last up to a few days following administration of the vaccine. ND pharmacists can give influenza vaccine 5 years and older.

Section IV.Signatures

I understand the benefits and risks of the vaccination(s) as described in the Vaccine Information Statement (VIS), a copy of which was provided with this Consent and Release. I request the vaccine(s) be given to me or to the person named below, a minor for whom I represent that I am authorized to sign this Consent and Release. I agree to wait near the vaccination location for approximately 15 minutes following vaccine administration to monitor for possible vaccine reactions.

Signature of Person to Receive Vaccine (or Parent/Guardian, if Recipient is a Minor) and Acknowledgement of Notice of

Privacy Practices and VIS:_____

Print Guardian name and number (If Recipient is a Minor):_____ **Date:**_____

_____**(Pharmacy Use Only)**_____

Vaccine	Date Administered	Vaccine Lot #	Expiration Date	MFR	Dosage	Site

☐ NDIIS

Signature of Pharmacist who administered vaccine(s):_____ **Date:**_____

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