

FLU / COVID / STREP TEST SCREENING FORM: PHARMACY

Last Name:		First Name:	
Date of Birth:		Phone Number:	
Allergies:			
Test:	<u>FLU A/B/COVID</u>		
Test:	<u>STREP</u>		

Are you experiencing any of the following symptoms? Check all that apply:

Fever (at or greater than 100 degrees Fahrenheit)

- ☐ Chills
- ☐ Cough
- ☐ Shortness of breath or difficulty breathing
- ☐ Fatigue
- ☐ Muscle or body aches
- ☐ Headache
- ☐ New loss of taste or smell
- ☐ Sore throat
- ☐ Congestion or runny nose
- ☐ Nausea or vomiting
- ☐ Diarrhea
- ☐ Swollen Lymph nodes

The pharmacy will refer patients with the any of the following symptoms/conditions for further medical evaluation:

- ☐ Patients that are pregnant
- ☐ Immunocompromised
- ☐ Any condition requiring supplemental oxygen therapy
- ☐ Patients <5
- ☐ Temperature >103° F
- ☐ Respiratory rate of >30 breaths per minute
- ☐ Oxygen saturation <94%
- ☐ Pulse > 125 beats per minute

The Pharmacist has explained the nature and purpose of the service being provided including potential benefits and risks. I understand that I have an opportunity to ask questions and have received satisfactory answers. By signing this form, I :

I Authorize the pharmacy and pharmacy staff to provide the agreed-upon service.

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I Authorize the pharmacy to communicate with my primary care provider if needed.

I Authorize the documentation of the service in my pharmacy recorded and applicable health registries as applicable by law.

Understand that emergency medical treatment may be sought if an adverse reaction occurs.

By signing this form, I hereby consent and state my preference to have Medicine Shoppe Pharmacy and its staff to test and treat based on results.

I agree to pay the \$90.00 fee that will be assessed for my appointment. I understand that this fee covers the appointment and the test. If results are positive and a prescription is provided, that will be processed through the pharmacy and may include an additional copay.

I acknowledge that the pharmacy follows privacy practices required by law and that my information maybe be used for treatment, payment, and healthcare operations.

I certify that I have read or had explained to me the information on this form, I understand the information provided to me, and I voluntarily consent to receive pharmacy services.

Printed name: _____

Signature: _____ Date: _____

*****FOR STAFF USE ONLY*****

PATIENT ASSESSMENT

TEMPERATURE _____

O2 _____

PULSE _____

BLOOD PRESSURE _____

__PATIENT QUALIFIES FOR TESTING

__PATIENT REFERRED TO PROVIDER

STAFF SIGNATURE _____ DATE _____

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. For other vaccines, (i.e. Pneumococcal, Shingles, Tdap), refer patient to the appropriate VIS

Inactivated Influenza Vaccine (injection) ages 6-months old and older: 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) ages 2-49: 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: _____