

# 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# : \_\_\_\_\_

## 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	2.	Do you have an <b>allergy</b> to medications, foods or any vaccines? For Example: Eggs, Gelatin, Thimerosal, Neomycin, Gentamicin, or Latex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	3.	Have you ever had a reaction or fainted after receiving any vaccination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	4.	<b>If you are over the age of 65:</b> Have you ever had a Pneumococcal vaccination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	5.	<b>If you are over the age of 50:</b> Have you ever had a Shingles vaccination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	6.	<b>For women:</b> Are you pregnant or are you planning on becoming pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	7.	Do you take any of the following "TNF Blockers" for the treatment of rheumatoid arthritis: etanercept (Enbrel), rituximab, adalimumab (Humira), or infliximab?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	8.	Have you ever had Guillain-Barre Syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LIVE	9.	Have you received any immunizations in the past 4 weeks? If yes, please specify:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	10.	Do you have cancer, leukemia, HIV, or any long term health condition (i.e. diabetes, asthma, other)? If yes, please specify:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	11.	Do you take cortisone, prednisone, other steroids, or anticancer drugs, or, have you had X-ray treatments recently?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	12.	During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## 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): \_\_\_\_\_

Print Guardian name and number (if Recipient is a Minor): \_\_\_\_\_ Date: \_\_\_\_\_

I have received a copy of the notice of Privacy Practices and appropriate CDC Vaccine Information Statement (VIS). I understand the notice of Privacy Practices provides an explanation of the ways in which my health information may be used or disclosed by the Pharmacy and of my rights with respect to my health information. I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.

Signature of Acknowledgment of Notice of Privacy Practices and VIS: \_\_\_\_\_ Date \_\_\_\_\_

(Pharmacy Use Only)

Vaccine	Date Administered	Vaccine Lot#	Expiration Date	MFR	Dosage	Site

Signature of Pharmacist who administered vaccine(s): \_\_\_\_\_ Date \_\_\_\_\_