# JONES DRUG STORE INFLUENZA SCREENING AND CONSENT FORM

## PATIENT INFORMATION (*Please print clearly)*

**Last Name: _________________________ First Name: ____________________ MI: _______**

**DOB: __________________ Gender: ☐ Male ☐ Female Age: _________**

**Street Address: ___________________________ City: _____________________ State: ______**

**Zip Code: __________ Phone #: _________________ Primary Care Physician: ____________**

**Social Security #: ______________________ Ethnicity/Race: ____________________**

## SCREENING QUESTIONNAIRE

***The following questions will help us determine your eligibility to be vaccinated today.***

| Please answer the following questions: | YES | NO | DON'T KNOW |
|---|---|---|---|
| **Are you feeling sick today?**<br>If YES, please circle if you are experiencing any of the following:<br>new fever cough diarrhea vomiting | | | |
| **Do you have any allergic reactions to medications, food (e.g. eggs or egg products), latex, vaccines or vaccine components?**<br>If YES, please list: | | | |
| **Have you ever had any serious reactions to any vaccination, including fainting and feeling dizzy?** | | | |
| **Have you ever had a health problem with lung, heart, kidney, liver or metabolic disease (e.g. diabetes), neurologic or neuromuscular disease, asthma, anemia, or another blood disorder?** | | | |
| **Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-Barre Syndrome, or other nervous system problems?** | | | |
| **Has any physician or other healthcare professional ever cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a physician's office or hospital?** | | | |
| **FOR WOMEN ONLY: Are you pregnant or considering becoming pregnant in the next month?** | | | |

**WHICH ARM WOULD YOU LIKE TO USE FOR YOUR FLU SHOT?** (circle one) **LEFT RIGHT**

**(OVER)**

I certify that I am: (a) the patient and at least 18 years of age or (b) the parent or legal guardian of the patient. Furthermore, I hereby give my consent to **JONES DRUG STORE** to administer the vaccine(s) I have requested above. I understand the risks and benefits associated with the above vaccine(s) and have received, read, and/or had explained to me the Vaccine Information Statements/Vaccine Fact Sheet(s) on the vaccine(s) I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless the applicable Provider, its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors, and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above. I acknowledge that I understand the purposes/benefits of my state's immunization registry ("State Registry") and the Provider may disclose my immunization information to the State Registry. I acknowledge that, depending upon my state's law, I may prevent the disclosure of my immunization information by the Provider to the State Registry by using the opt-out form. The Provider will, if my state permits, provide me with an Opt-Out form. I understand that, depending on my state's laws, I may need to specifically consent, and to the extent required by my state's law, by signing below, I hereby do consent to the Provider reporting my immunization information to the State Registry. I understand that even if I do not consent or if I withdraw my consent, my state's laws may permit certain disclosures of my information as required or permitted by law. I voluntarily authorize and direct my healthcare provider, **JONES DRUG STORE**, to use or disclose my health information during the term of this Authorization to the physician responsible for this protocol of specific health information of people vaccinated at **JONES DRUG STORE**, my primary care physician, my insurance and/or state or federal registries, where required, for the purpose of treatment, payment or other healthcare operations. I further agree to be fully financially responsible for any cost sharing amounts, including copays, coinsurance, and deductibles, for the requested items and services as well as for any requested items and services not covered by my insurance benefits. I understand that any payment for which I am financially responsible is due at the time of service.

**Patient Name: ______________________________** *(Please print clearly)*

**Patient Signature: _______________________________ Date: _______________**

**PHARMACY USE ONLY BELOW**

**VACCINE:** (circle) FLUZONE HD 65+ 22-23 FLUZONE QUAD 22-23 AFLURIA QUAD 22-23

Administration Date: _____________ Lot # & EXP: _________________ VIS: _________

Administration Site: (circle one) LEFT ARM RIGHT ARM Administration Route: IM

Pharmacist Signature: ______________________ Admin Date and VIS given to patient: _______