Screening Checklist for contraindications to Vaccines for Adults

PINE BROOK PHARMACY
Dispensing Healthier Life
www.PineBrookPharmacy.com

Name: _____
Date of Birth: _____/_____/_____ Phone Number: (_____)_____
Address: _____
City: _____State: _____Zip: _____

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

Please check off which vaccinations you would like to receive:

Flu Vaccine (3+) ☐	Shingles Vaccine (50+) ☐	Pneumonia (65+. Adults 19-64 with Certain Conditions) ☐	T-DAP Vaccine (Once every 10 years or following injury) ☐
High Dose Flu Vaccine (65+) ☐	RSV Vaccine (60+) ☐	Hepatitis AB Vaccine ☐	COVID-19 Vaccine: (approved Under EUA only) ☐

Please answer these questions:	Yes	No	Unsure
1. Are you sick today?	☐	☐	☐
2. Do you have allergies to medications, food, a vaccine component, or latex?	☐	☐	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☐	☐
4. Do you have a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Are you on long-term aspirin therapy?	☐	☐	☐
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
6. Do you have a parent, brother, or sister with an immune system problem?	☐	☐	☐
7. In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?	☐	☐	☐
8. Have you had a seizure or a brain or other nervous system problem?	☐	☐	☐
9. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
10. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
11. Have you received any vaccinations in the past 4 weeks?	☐	☐	☐

FORM COMPLETED BY_____ DATE_____

FORM REVIEWED BY _____ DATE_____

IMMUNIZATION_____INJ SITE_____

NDC_____ LOT_____ EXP_____ MANUF_____

I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient and confirm that the patient is at least 18 years of age; or (c) legally authorized to consent for vaccination for the patient named above. Further, I hereby give my consent to Pine Brook Pharmacy or its agents to administer the requested vaccine(s).

- I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine and have received, read and/or had explained to me the VIS or Emergency Use Authorization Fact Sheet 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.
- I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes (or more in specific cases) after administration for observation. If I experience a severe reaction, I will call 9-1-1 or go to the nearest hospital.
- On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless the State of Florida, the Florida Department of Health, Florida Division of Emergency Management, Pine Brook Pharmacy and their 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 listed above.
- I acknowledge that: (a) I understand the purposes/benefits of Florida SHOTS, Florida's immunization registry and (b) Pine Brook Pharmacy will include my personal immunization information in Florida SHOTS and my personal immunization information will be shared with the Centers for Disease Control (CDC) or other federal agencies.
- I acknowledge receipt of the Pine Brook Pharmacy Notice of Privacy Practices.