Lewisville Drug Immunization Questionnaire and Consent Form

☐ Medicare #: ______________________ ☐ Cash:
Insurance Carrier: ______________ Group#: ______________ ID#: ______________

Patient Information (please print):

Patient's Full Name: ______________________ DOB: __________ Age: ______
Address: ______________________ City: ______________ State: ________ Zip: __________
Phone: ______________________ Email: ______________________ Gender: M F
Which vaccine(s) would you like to receive today?: ______________________
Any medical conditions?: ______________________
Primary Doctor: ______________________ Primary Doctor Phone: ______________________

By providing your email address you are agreeing to receive information via email from Lewisville Drug. You may opt out of the email communications at any time. We value your privacy and, as a result, we will never share or sell your information with any outside manufacturers or marketers.

Please answer these questions by placing an "X" in the correct box to the right of the question. If a question is not clear, please ask your pharmacist to explain it.	Yes	No	Don't Know
1. Do you feel sick today?			
2. Do you have an allergy to medications, foods or vaccines? If yes, please circle which: eggs, gelatin, thimerosal, neomycin, gentamicin, latex, baker's yeast, aluminum, preservatives, other:__________			
3. Have you ever had a serious reaction or fainted after receiving a vaccination?			
4. Have you ever had a seizure disorder, brain disorder, or Guillain-Barre Syndrome?			
5. Have you received any vaccinations or TB skin test in the past 4 weeks?			
6. Do you have a long-term health problem such as heart disease, lung cancer, liver disease, asthma, kidney disease, metabolic disease (e.g. diabetes), anemia, or other blood disorder?			
7. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem? Have you been diagnosed with rheumatoid arthritis, ankylosing spondylitis, Chron's disase?			
8. In the past 3 months, have you taken cortixone, prednisone, other steriods, or anticancer drugs, or, have you had an x-ray or radiation treatments?			
9. During the past year, have you received a transfusion of blood or blood products or been given a medicine called immune (gamma) blobulin or an intiviral drug?			
10. **For Women:** Are you pregnant or could you become pregnant in the next 3 months?			
11. **For the Td or Tdap vaccine:** Do you have a cut, injury, puncture or open wound that prompted you to get a tetanus shot?*			
12. **If you are over the age of 65:** Have you ever had a pneumococcal vaccination?			
13. **If you are over the age of 50:** Have you ever had a shingles vaccination?			
14. **For the Zostavax vaccine:** Have you had a past reaction to gelatin or triple antibiotic ointment?			
15. Has any physician or other healthcare professional ever cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a medical setting?			
16. Did you bring your immunization record with you?			
Have you ever had the following vaccines:			
Pneumococcal			
Shingles			
Whooping Cough (Tdap)			

* An immunization can not be given if there is an affirmative answer to these questions

I authorize the pharmacist to send copies of my vaccine documents to may primary care provider: ☐ Yes ☐ No

Failure to select one of these boxes will result in the vaccine documents being sent to my primary care provider, if known, as state laws & regulations require for North Carolina.

I authorize the release of any other medical or other information with respect to this vaccine to my healthcare providers, Medicare, Medicaid or other third party payer as needed and request payment of authorized benefits to be made on my behalf to Lewisville Drug.

- I acknowledge that if my insurance does not cover the cost of administering the vaccine at the pharmacy, then payment must be made at the time of the administration of the vaccine.
- I acknowledge that my vaccination record may be shared with federal or state or city agencies for registry reporting.
- I acknowledge that the pharmacist recommends that vaccinated patients should remain in the waiting area, for 20 minutes, after the administration of the immunization.
- I acknowledge receipt of Lewisville Drug's notice of Privacy Practices for Protected Health Information.
- I have read, or have had read to me, the vaccination information sheet (VIS) regarding the vaccine(s). I have had the opportunity to ask questions that were answered to my satisfaction and understand the benefits and risks of the vaccine (s). I consent to, or give consent for, the administration of the vaccine(s). I fully release and discharge Lewisville Drug, its affiliates, officers, directors, and employees from any liability for illness, injury, loss, or damage which may result there from.

Patient Signature (if under the ate of 18: Parent/legal guardian signature): ______________________ **Date:** __________

Pharmacy Use Only

☐ Influenza Injectable	VIS Date: ________	☐ MMR	VIS Date: ________
☐ Pneumococcal	VIS Date: ________	☐ DTaP	VIS Date: ________
☐ Hepatitis B	VIS Date: ________	☐ Zoster(Shingles)	VIS Date: ________
☐ HPV	VIS Date: ________	☐ Tdap	VIS Date: ________
☐ Varicella	VIS Date: ________	☐ Hepatitis A & B	VIS Date: ________
☐ IPV	VIS Date: ________	☐ Influenza Nasal	VIS Date: ________
☐ Meningococcal	VIS Date: ________	☐ Hib	VIS Date: ________
☐ TD	VIS Date: ________	☐ Other:	VIS Date: ________
☐ Hepatitis A	VIS Date: ________	________	VIS Date: ________

Lot #: __________ Lot #: __________
Exp Date: __________ Exp Date: __________
Site LA or RA (circle one) Site LA or RA (circle one)

Signature of pharmacist who administered the vaccine:
____
License #: ______________
Date: ______________