Screening Questionnaire and Consent Form for Vaccinations

Name: _____ Date of Birth: _____ Age: _____ Phone #:_____
Address: _____ City: _____ State: _____ Zip: _____ Gender: M / F
☐ I am a MSU Health Care worker or MSU student enrolled in health care program

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐ Unknown ☐ Prefer not to answer
Race: ☐American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American ☐White
☐ Other ☐ Prefer not to answer

Please check the vaccine(s) you would like to receive today:

☐ Flu ☐ Shingles ☐ Tetanus ☐ Pneumonia ☐ Hepatitis A
☐ Flu High dose ☐ COVID-19 ☐ Tetanus with Pertussis ☐ RSV ☐ Hepatitis B

The following questions will help us determine if the vaccine requested may be administered today. If a question is not clear, please ask your pharmacist to explain it.	**Yes**	**No**	**I Don't Know**
Are you sick today?			
Do you have any allergies to medications, food, latex, or any vaccine component? *			
Have you ever had a serious reaction after receiving a vaccine?			
Do you have any of the following: a long-term health problem with heart, lung, liver, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak?			
Do you have cancer, leukemia, AIDS, or any other immune system problem?			
In the past 6 months, have you taken medications that weaken your immune system such as prednisone, other steroids, anticancer drugs, or drugs for the treatment of rheumatoid arthritis, Crohn's disease, psoriasis, or any other autoimmune disorder?			
Have you had a seizure, a brain, or other nervous system problem?			
During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin?			
Do you reside in a long-term care facility?			
Have you received another vaccine within the past 4 weeks? Do you plan on receiving another vaccine in the next 4 weeks?			
For women: are you pregnant or could you become pregnant?			
Shingrix only: For patients interested in receiving a Shingrix (shingles) vaccine – eligible persons include all patients ≥50 years old or immunocompromised patients ≥19 years old:			
• Ages 19 to 49 – have you received the Varicella vaccine or have history of chickenpox?			
• Have you ever received a Zostavax or Shingrix (shingles) vaccine?			
COVID-19 only: For patients 12-64 years old interested in receiving a COVID-19 vaccine, please review the attached sheet. Indicate on this form if any of the listed conditions apply to you.			

*e.g. neomycin, formaldehyde, gentamicin, thimerosal, bovine protein, phenol, polymyxin, gelatin, baker's yeast or yeast, polyethylene glycol, etc.

If you answered yes to any of the above, please explain:

_____

I authorize the release of any medical or other information with respect to this vaccine to my health care provider or third-party payer as needed and request payment of authorized benefits to be made on my behalf to Michigan State University Pharmacy.

- 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 vaccine administration.
- I acknowledge that my vaccination record may be shared with federal, state, or city agencies for registry reporting.
- I acknowledge that the pharmacist recommends that vaccinated patients should remain in the waiting area for at least 20 minutes following vaccine administration.
- I acknowledge receipt of Michigan State University Health Care's notice of privacy practices for Protected Health Information (PHI).

I have read, or have had read to me, the Vaccination Information Sheet (VIS) regarding the vaccine. I have had the opportunity to ask questions, which were answered to my satisfaction, and understand the benefits and risks of the vaccine. I consent to, or give consent for, the administration of the vaccine. I fully release and discharge Michigan State University from any liability for illness, injury, loss, or damage which may result there from.

Patient (Parent or Guardian if under 18) Signature: _____Date: _____

Vaccine 1 **Place Rx Label Here**	**Vaccine 2** **Place Rx Label Here**
(Vaccine 1) **VIS Date: _____** **Date VIS given to patient: _____** **Lot #: _____** **Exp Date: _____** **Site: LA or RA** **□ MCIR submission complete**	**(Vaccine 2)** **VIS Date: _____** **Date VIS given to patient: _____** **Lot #: _____** **Exp Date: _____** **Site: LA or RA** **□ MCIR submission complete**
(Vaccine 3) **VIS Date: _____** **Date VIS given to patient: _____** **Lot #: _____** **Exp Date: _____** **Site: LA or RA** **□ MCIR submission complete**	**(Vaccine 4)** **VIS Date: _____** **Date VIS given to patient: _____** **Lot #: _____** **Exp Date: _____** **Site: LA or RA** **□ MCIR submission complete**
Vaccine 3 **Place Rx Label Here**	**Vaccine 4** **Place Rx Label Here**

Vaccine(s) administered by: _____

□ Printed notification form to fax to University Phys Office (MSU Health Cre worker or student – Flu vaccine only)

[Form last revised 9-21-2023]

COVID-19 only: For patients 12-64 years old interested in receiving a COVID-19 vaccine, please review the following questions. Please indicate on the Screening Questionnaire and Consent Form for Vaccination if any of the conditions listed below apply to you and explain.

If you are receiving the COVID-19 vaccine, please complete the following box.

The following questions will help us determine if the vaccine requested may be administered today*. If a question is not clear, please ask your pharmacist to explain it.	**Yes**	**No**	**I Don't Know**
Do you have cancer? Are you receiving cancer treatment?			
Do you have cerebrovascular disease, a condition that affects blood flow to the brain? Have you ever had a stroke?			
Do you have any heart conditions? This includes heart failure, coronary artery disease, cardiomyopathies, and possibly high blood pressure.			
Do you have chronic kidney disease?			
Do you have chronic liver disease? This includes alcohol-related liver disease, non-alcoholic fatty liver disease, autoimmune hepatitis, and cirrhosis.			
Do you have a chronic lung disease? This includes asthma, bronchiectasis, bronchopulmonary dysplasia, COPD, emphysema, chronic bronchitis, damaged or scarred lung tissue, pulmonary hypertension, or a history of pulmonary embolism (a blood clot in the lungs).			
Do you have cystic fibrosis?			
Do you have dementia or Parkinson's Disease?			
Do you have type 1 or 2 diabetes?			
Do you have any disabilities?			
Do you have any hemoglobin disorders, such as Sickle Cell Disease or thalassemia?			
Do you have human immunodeficiency virus (HIV)?			
Are you immunocompromised or have a weakened immune system? This includes people who have cancer and are on chemotherapy, people who have a solid organ transplant and are taking medication to keep their transplant, people who use corticosteroids for a long time, or people who have a primary immunodeficiency.			
Do you have any mental health conditions, including depression and schizophrenia spectrum disorders?			
Are you overweight or obese? Is your BMI 25 kg/m^2 or above?			
Are you physically inactive?			
Are you pregnant or did you have a recent pregnancy?			
Are you a current or former smoker?			
Have you received a solid organ or blood stem cell transplant?			
Do you have a substance use disorder with alcohol, opioids, or cocaine?			
Do you have tuberculosis?			

*This list does not include all medical conditions that place a person at higher risk of severe illness from COVID-19. Rare medical conditions may not be included. It is important to talk with your healthcare provider about your risk – a person with a condition that is not listed may still be at greater risk of getting very sick from COVID-19 than other people.