Screening Questionnaire and Consent Form for Vaccinations

Patient Information: (patient to complete)

Name: _____ Date of Birth: _____ Age: _____ Phone #:_____
Address: _____ City: _____ State: _____ Zip: _____ Gender: M / F
Medical Conditions: _____ Weight: _____ (if less than 110 pounds)
Primary Doctor: _____ Dr. Phone #: _____
Alternative Doctor: _____ Dr. Phone #: _____

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**
Have you ever received a Zostavax or Shingrix (shingles) vaccine?			
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 cancer, leukemia, AIDS, or any other immune system problem?			
Do you take drugs 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 radiation treatment?			
Have you taken anti-virus drugs (i.e. acyclovir, famciclovir, or valacyclovir) in the past day or do you plan on taking one of these medications over the next 2 weeks?			
During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin?			
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?			
For patients over 65 years of age and patients that have a chronic condition such as Asthma or COPD, or Smoke: Have you received the Pneumococcal or "Pneumonia" vaccine?			

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

If yes, 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 HealthTeam'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 Signature: _____

Date: _____

For Pharmacy Use Only

Vaccine(s) patient is receiving:

□ **Influenza** (Normal / High-dose) MSU HCW/HCP Student → Notify University Physician	**VIS Date: _____** **Date VIS given to patient: _____** **Lot #: _____** **Exp Date: _____** **Site: LA or RA**	Place RX Label Here
□ **Shingles** (Dose #1 / Dose #2)	**VIS Date: _____** **Date VIS given to patient: _____** **Lot #: _____** **Exp Date: _____** **Site: LA or RA**	Place RX Label Here
□ **Tetanus, diphtheria, pertussis (Tdap)** □ **Tetanus diphtheria (Td)**	**VIS Date: _____** **Date VIS given to patient: _____** **Lot #: _____** **Exp Date: _____** **Site: LA or RA**	Place RX Label Here
□ **Pneumonia (Pneumovax – PPSV23)** □ **Pneumonia (Prevnar 13 – PCV13)**	**VIS Date: _____** **Date VIS given to patient: _____** **Lot #: _____** **Exp Date: _____** **Site: LA or RA**	Place RX Label Here

Signature of Pharmacist/pharmacy student who administered Vaccine(s): _____

□ MCIR submission complete
□ Primary Physician Fax complete