Hoagland Pharmacy

Screening Questionnaire for Immunization and Consent

☐ Medicare# _____ Appt Date _____
☐ Cash _____ Appt Time _____

Patient Name: _____, _____ Date of Birth: ___/___/_____ Gender: M / F Phone #:(___)_____-_____
First Name Last Name Middle Init.

Address: _____ City: _____ State: _____ Zip: _____

Primary Doctor: _____ Allergies: _____

Medical Conditions: _____

For Travel Vaccines: Traveling To: _____ Date Leaving: ___/___/_____

The following questions will help us determine which vaccines may be given today. If a question is not clear, please ask your pharmacist/ nurse to explain it.

YES	NO	NOT SURE	
☐	☐	☐	Are you sick today?
☐	☐	☐	Do you have allergies to medications, food (IE. eggs) or any vaccine?
☐	☐	☐	Have you ever had a serious reaction after receiving a vaccination?
☐	☐	☐	Do you have cancer, leukemia, AIDS, or any other immune system problem?
☐	☐	☐	Do you take cortisone, prednisone, other steroids, antivirals, antibiotics, or anticancer drugs, or are you undergoing any - radiation treatments?
☐	☐	☐	In the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin?
☐	☐	☐	Have you received any vaccinations in the past four weeks?
☐	☐	☐	Do you have a neurological disorder that resulted from a vaccine?
☐	☐	☐	Did you bring your immunization record card with you?
☐	☐	☐	For women: Are you pregnant or is there a chance you could become pregnant in the next month?

Which vaccine would you like to receive today?

Please check all that apply:

- ☐ Hepatitis A (Havrix) QTY: 1mL Refills: 1 Inject 1mL IM now, repeat in 6 months
- ☐ Hepatitis A/B (TwinRix) QTY: 1mL Refills: 2 Inject 1mL IM now, repeat in 1 month and 6 months
- ☐ Hepatitis B (Heplisav) QTY: 0.5mL Refills: 1 Inject 0.5mL IM now, repeat in 1 month
- ☐ Hepatitis B (Engerix) QTY: 1mL Refills: 2 Inject 1mL IM now, repeat in 1 month and 6 months
- ☐ Haemophilus B (Hib) QTY: 0.5mL Refills: 0 Inject 0.5mL IM
- ☐ HPV (Gardasil 9) QTY: 0.5mL Refills: 2 Inject 0.5mL IM now, repeat in 2 months and 6 months
- ☐ Japanese Encephalitis (IXIARO) QTY: 0.5mL Refills: 1 Inject 0.5mL IM on days 0 and 7 or 28
- ☐ Measles/Mumps/Rubella (MMR) QTY: 1mL Refills: 1 Inject 0.5mL SQ May repeat in 28 days
- ☐ Meningitis B (Bexsero) QTY: 0.5mL Refills: 1 Inject 0.5mL IM on days 1 and 28
- ☐ Meningitis (Menactra) QTY:0.5mL Refills: 0 Inject 0.5mL IM
- ☐ Pneumococcal (Pneumovax) QTY: 0.5mL Refills: 0 Inject 0.5mL SQ or IM
- ☐ Pneumococcal 13 (Prevnar) QTY: 0.5mL Refills: 0 Inject 0.5mL IM
- ☐ Pneumococcal 20 (Prevnar) QTY: 0.5mL Refills: 0 Inject 0.5mL IM
- ☐ Polio (IPOL) QTY: 0.5mL Refills: 0 Inject 0.5mL SQ or IM
- ☐ Rabies (Rabavert) QTY: 1mL Refills: 2 Inject 1mL IM in days 0, 7 and 21 or 28
- ☐ Seasonal Influenza _____
- ☐ Shingles (Shingrix) QTY: 1mL Refills: 1 Inject 0.5mL IM now, repeat in 2 to 6 months
- ☐ Tetanus/Diptheria (Tenivac) QTY: 0.5mL Refills: 0 Inject 0.5mL IM
- ☐ Tet/Diph/Ac Pert (Adacel) QTY: 0.5mL Refills:0 Inject 0.5mL IM
- ☐ Typhoid (Typhim) QTY: 0.5mL Refills:0 Inject 0.5mL IM
- ☐ Varicella (Varivax) QTY: 1mL Refills: 1 Inject 0.5mL SQ. May repeat in 28 days
- ☐ Yellow Fever (YF-VAX) QTY: 1mL Refills: 0 Inject 0.5mL SQ

I have read, or have had read to me, the Vaccination Information Sheet (VIS) regarding the vaccine(s) marked above. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s). I consent to, or give consent for, the administration of the vaccine(s) marked above and the notification of my primary care physician. I fully release and discharge Hoagland Pharmacy, its affiliates, directors, and employees from any liability for illness, injury, loss, or damage which may result there from.

Patient Name (print): _____ Patient Signature: _____

If not the patient, this form was completed by: _____ Relation to Patient: _____

If the patient is under the age of 18: Parent or legal guardian signature: _____

Medicare Recipients Please Complete This Section Below:

Please check one:

☐ I hereby authorize the pharmacy to bill Medicare Part B on my behalf. I request that payment of authorized Medicare benefits be made to the pharmacy for **the marked vaccine(s)** and administration as furnished to me by the pharmacy. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits payable for related services.

☐ I hereby attest that as of the date indicated above, I am not enrolled in Medicare Part B

Patient Signature: _____ **Prescriber Signature:** _____

Manufacturer: _____	Manufacturer: _____	Manufacturer: _____	Manufacturer: _____	Manufacturer: _____
Lot #: _____	Lot #: _____	Lot #: _____	Lot #: _____	Lot #: _____
Exp Date: _____	Exp Date: _____	Exp Date: _____	Exp Date: _____	Exp Date: _____
Site of Vaccination: _____	Site of Vaccination: _____	Site of Vaccination: _____	Site of Vaccination: _____	Site of Vaccination: _____
VIS Date: _____	VIS Date: _____	VIS Date: _____	VIS Date: _____	VIS Date: _____

Signature of person who administered vaccine(s): _____ **Date:** _____

V.032222_SB