# Immunization Consent Form

Name (as it appears on insurance card): ________________________________

Date of Birth: ____________________ Age: ______ Gender (circle one): Male / Female

Street Address: ________________________________________________

City: ____________________________ State: ______ Zip Code: ______________________

Family Doctor: __________________ Method of payment: Cash / Insurance (please provide card to pharmacy)

Screening Questions (if you answer yes, please explain below) | Please circle

| | Question | Please circle | |
|---|---|---|---|
| 1. | Are you sick today? | Yes | No |
| 2. | Do you have allergies to medications, food, a vaccine component, or latex? | Yes | No |
| 3. | Have you ever had a serious reaction after receiving a vaccination? | Yes | No |
| 4. | Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder? | Yes | No |
| 5. | Do you have cancer, leukemia, AIDS, or any other immune system problem? | Yes | No |
| 6. | Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments? | Yes | No |
| 7. | Have you had a seizure or a brain or other nervous system problem? | Yes | No |
| 8. | During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? | Yes | No |
| 9. | For women: Are you pregnant or is there a chance you could become pregnant during the next month? | Yes | No |
| 10. | Have you received any vaccinations in the past 4 weeks? | Yes | No |

**Consent and waiver:** I consent to the staff to administer the medication(s) mentioned below. I have reviewed the vaccine information sheet (s) and understand the benefits and risks of receiving this medication and choose to assume this risk. I fully release and discharge the **standing order physician Dr D. McAfee** and the pharmacy, its affiliations and their officers, and employees from any illness, injury, loss, or damage that may result there from. I acknowledge that ***I have received a copy of the pharmacy's privacy policies according to HIPAA***. I assign payment of authorized insurance benefits due to me to be paid to the pharmacy and will pay any copay or deductible that result. I consent the release of medical information when necessary for billing, reimbursement, and medical protocol. I also allow for the pharmacy to report any medications received to the appropriate state vaccine registry. I am aware that an immunization certified student pharmacist might be administering this medication. **I agree to wait near the vaccination area for approximately 20 minutes to receive treatment in case of adverse reaction.**

Signature of patient X:________________________________ Date:______________

Below is for pharmacy documentation

- [ ] Medication:________________ VIS Date: _______ Lot #:____________ Exp Date: _______ Site: ____
- [ ] Medication:________________ VIS Date: _______ Lot #:____________ Exp Date: _______ Site: ____

Administered by: ___________________________ Title: ____________ Date Given:_____________

# Arkansas Department of Health

4815 West Markham Street • Little Rock, Arkansas 72205-3867 • Telephone (501) 661-2000
Governor Asa Hutchinson
Nathaniel Smith, MD, MPH, Secretary of Health

## PHARMACY PATIENT SCREENING QUESTIONNAIRE COVID-19

Specific services such as vaccine administration or disease state management require pharmacists and patients to be in close proximity. To prevent the spread of the novel coronavirus (COVID-19) and decrease the risk of exposure to other patients and pharmacy staff, please complete this form and provide to the pharmacy prior to arrival:

| Date: | |
|---|---|
| Name (Please Print): | |
| Date of Birth: | |
| Service Requested: | |

**Within the last 24 hours, please answer if have you experienced any of the following symptoms:**

| Fever of 100.4° or more | Yes / No | Cough | Yes / No |
|---|---|---|---|
| Headache | Yes / No | Difficulty Breathing/ Shortness of Breath | Yes / No |
| Sore Throat | Yes / No | Your Current Temperature Reading | |

**Additional Questions**:

| Have you returned from international or out-of-state travel, or a cruise within the last 14 days? | Yes / No |
|---|---|
| Are you 65 years old or older? | Yes / No |
| Are you immunocompromised or have other diseases that put you at risk for COVID-19 such as cardiovascular disease, asthma/COPD, autoimmune disease or diabetes? If yes, please indicate: | Yes / No |
| Have you been exposed to a person who has been diagnosed with COVID-19? | Yes / No |
| Have you been exposed to a person who is under investigation for COVID-19? | Yes / No |

April 4, 2020

If you have any of the above listed symptoms and/or answered yes to any of the additional questions, please call your pharmacist to discuss before entering the pharmacy. For information about COVID-19, please go to https://www.healthy.arkansas.gov/programs-services/topics/novel-coronavirus . You may also call the Arkansas Department of Health at 1-800-803-7847 or email ADH.CoronaVirus@arkansas.gov.

**Upon Arrival:**

| **Temperature checked at Pharmacy (checked by pharmacist)** | |
|---|---|

**Patient Signature/Date**

X ______________________________________

**(Information is confidential. Please note, services are subject to change and may be unavailable per pharmacist's discretion)**