Rock Ridge Pharmacy

191 Rock Rd, Glen Rock, NJ 07452

Consent Form and Screening Questionnaire for Immunization

Section I. Personal information

Patient's Full Name (First, Last): _____ Date of Birth: _____ Age: _____

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

Phone Number and Email Address: _____ Gender: ___M ___F

Primary Care Doctor: _____ Doctor's Number: _____

Section II. Questionnaire for Immunization

	Please answer these questions by checking the boxes.	Yes	No
1.	Do you feel sick today?		
2.	Do you have an **allergy** to medications, foods or any vaccines? If yes circle which one: eggs, gelatin, thimerosal, neomycin, gentamicin, latex, baker's yeast, aluminum, preservatives, other:	☐	☐
3.	Have you ever had a serious reaction or fainted after receiving any vaccination?	☐	☐
4.	Have you ever had a seizure disorder, brain disorder, or Guillain-Barre Syndrome?	☐	☐
5.	**For women:** Are you pregnant or are you planning on becoming pregnant during the next month?	☐	☐
6.	Do you have a long-term health problem with heart, lung, kidney or metabolic disease (e.g. diabetes), asthma, anemia or a blood/bleeding disorder? If yes, please specify:	☐	☐
7.	Have you received any immunizations in the past 4 weeks? If yes, please specify:	☐	☐
8.	**For children/teens:** Has the child, sibling, or parent had a seizure; has the child had brain or other nervous system problems?	☐	☐
9.	**If you are over the age of 65:** Have you ever had a pneumococcal vaccination?		
10.	**If you are over the age of 50:** Have you ever had a shingles vaccination?		
11.	Do you have cancer, leukemia, HIV/AIDS, history of a transplant, or an autoimmune disorder?	☐	☐
12.	In the past 3 months, have you taken cortisone, prednisone, other steroids, or anticancer drugs, or, have you had an x-ray or radiation treatments?	☐	☐

Section III. Signatures

I understand the benefits and risks of the vaccination(s) as described in the Vaccine Information Statement (VIS), a copy of which was provided with this Consent and Release. I request the vaccine(s) be given to me or to the person named below, a minor for whom I represent that I am authorized to sign this Consent and Release. I have received a copy of the notice of Privacy Practices and appropriate CDC Vaccine Information Statement (VIS). I understand the notice of Privacy Practices provides an explanation of the ways in which my health information may be used or disclosed by the Pharmacy and of my rights with respect to my health information. I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.

Signature of Person to Receive Vaccine: _____ **Date:** _____

☐ I hereby authorize the pharmacy to bill my insurance and receive payment on my behalf for the immunizations.

(Pharmacy Use Only)

Vaccine	Lot#	MFR	Exp. Date	Dosage	Injection Site	VIS Date

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