

LAST NAME	FIRST NAME	MI	Birthdate
ADDRESS	CITY	STATE	ZIP
10-DIGITPHONE			
Primary Physician			

For the safety of other customers and our employees, let's first get these familiar questions out of the way. Please answer this brief COVID-19 questionnaire for the person being scheduled. All fields are required.

1. In the past two weeks, have you tested positive for COVID-19 or are you currently being monitored for COVID -19? Yes No
2. In the past two weeks, have you had contact with someone who tested positive for COVID-19 ? Yes No
3. Do you currently or have you in the past 14 days, experienced the new onset of a fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, vomiting, or diarrhea? Yes No

PRECAUTIONS AND CONTRAINDICATIONS (Please check yes or no for each question.)

- | | |
|--|---|
| 1. Are you sick today? <input type="checkbox"/> Yes <input type="checkbox"/> No | steroids, or anticancer drugs; drugs for treatment of rheumatoid arthritis, Crohn's disease, or psoriasis, or have you had radiation treatments? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Do you have allergies to medications, food, a vaccine component, or latex? <input type="checkbox"/> Yes <input type="checkbox"/> No | 7. Have you had a seizure or a brain or other nervous system problem? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Have you ever had a serious reaction after receiving a vaccination? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No | 9. For women: Are you pregnant or is there a chance you could become pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problems? <input type="checkbox"/> Yes <input type="checkbox"/> No | 10. Have you received any vaccinations in the past 4 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other | |

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 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 reviewed the pharmacy's privacy policies according to HIPPA**. I assign payment of authorized insurance benefits due to me to be paid to the pharmacy and will pay any co pay 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 pharmacist might be administering this medication. I agree to wait near the vaccination area for approximately 10-15 minutes to receive treatment in case of adverse reaction.

SIGNATURE

DATE

ADMINISTRATIVE RECORD FOR PHARMACY USE ONLY

PHARMACIST SIGNATURE	DATE
VACCINE: SHINGRIX / TDAP/ INFLUENZA	SITE OF INJECTION: Left Arm / Right Arm
Pneumonia (Prevnar13 & Pneumovax 23)	
LOT NUMBER: _____	
EXPIRATION DATE: _____	
MANUFACTURER:	
VIS Date:	