Consent Form and Screening Questionnaire for Immunization | Wilmont Pharmacy

Section I. Personal information (Please print neatly.)

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

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

Phone: _____ **Email Address:** _____ **Gender:** ___M ___F

Primary Care Doctor: _____ **Doctor City/State:** _____

Section II. Questionnaire for Immunization

		Please answer these questions by checking the boxes.	Yes	No	Don't Know
FLU	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.	**For children ages 2-4:** Has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	☐	☐	☐
	7.	I**f you are over the age of 50:** Have you had a shingles vaccination or been diagnosed with shingles in last 12 months??	☐	☐	☐
	8.	**If you are over the age of 65:** Have you ever had a pneumococcal vaccination?	☐	☐	☐
OTHER	9.	**For children/teens:** Has the child, sibling, or parent had a seizure; has the child had brain or other nervous system problems?	☐	☐	☐
	10.	Do you have a long-term health problem with heart, lung, kidney, diabetes, asthma, no spleen, cochlear implant, anemia or a blood/bleeding disorder? If yes, please specify:	☐	☐	☐
	11.	Have you received any immunizations in the past 4 weeks? If yes, please specify:	☐	☐	☐
	12.	Do you have cancer, leukemia, HIV/AIDS, history of a transplant, or an autoimmune disorder?	☐	☐	☐
	13.	In the past 3 months, have you taken medications that affect immune system such as prednisone, other steroids, or anticancer drugs, drugs for autoimmune disease (RA, Crohn's, etc.) or had radiation?	☐	☐	☐
	14.	During the past year, have you received a transfusion of blood or blood products or been given a medicine called immune (gamma) globulin or an antiviral drug?	☐	☐	☐

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.

Signature of Person to Receive Vaccine & VIS: _____ **Date:** _____
(or Parent/Guardian, if Recipient is a Minor (<18yr old))

I have received a copy of the notice of Privacy Practices. I understand the notice of Privacy Practices provides an explanation of the ways in which my health information may be used or disclosed by Wilmont 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 Acknowledgment of Notice of Privacy Practices: _____ **Date:** _____

Insurance Information & Authorization:
☐ I hereby authorize Wilmont Pharmacy to bill my Insurance on my behalf for the immunizations and receive payment.

Member #: _____ **BIN #:** _____ **PCN #:** _____

_ *(Pharmacy Use Only)* _

Vaccine	Brand Name & MFR	Vaccine Lot #	Expiration Date	Dosage	Injection Site	VIS Date	STATUS
Seasonal Influenza QUAD HD FLUAD MIST				0.5mL 0.25mL 0.2mL	R L Arm Thigh Intranasal IM SQ		☐Billed
Pneumococcal PNEUMOVAX PREVNAR				0.5mL 0.25mL	R L Arm Thigh Intranasal IM SQ		☐Iris
Shingles SHINGRIX ZOSTAVAX				0.65mL 0.5mL	R L Arm Thigh Intranasal IM SQ		☐Fax PCP
Other:					R L Arm Thigh Intranasal IM SQ		☐Scanned

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