

IMMUNIZATION SCREENING AND CONSENT FORM

PATIENT INFORMATION (PLEASE PRINT CLEARLY)

Last Name: _____ First Name: _____ MI: _____

D.O.B.: _____ Age: _____ Gender: _____ Phone: _____

Home Address: _____ City/State/Zip: _____

Primary Care Physician: _____

Which vaccine(s) would the patient like to receive today?

<input type="checkbox"/> Influenza (Fluarix 3 years and older)	<input type="checkbox"/> Shingles (Shingrix) (must be 50 years or older, two shot series, 2nd dose in 2-6 months after first dose)
<input type="checkbox"/> Influenza (Fluzone High Dose 65 years and older)	<input type="checkbox"/> COVID-19 (Moderna Spikevax 12 yrs & older)
<input type="checkbox"/> Pneumonia (Prevnar 20)	<input type="checkbox"/> Tetanus/Whooping Cough (Boostrix)
<input type="checkbox"/> RSV (Abrysvo) (must be 60 yrs or older or high risk)	

Race: _____ Ethnicity: _____ Administration Site: ☐ Left ☐ Right Deltoid

Emergency Contact: _____ Relationship: _____ Phone: _____

SCREENING QUESTIONNAIRE

The following questions will help us determine your eligibility to be vaccinated today.

ALL VACCINES	Yes	No	N/A
Are you feeling sick or experiencing a moderate to high fever today?			
Do you have any allergies to medications, food (i.e., eggs), latex, vaccine components (e.g. neomycin, formaldehyde, gentamicin, thimerosal, bovine protein, phenol, polymyxin, gelatin, polysorbate, polyethylene glycol, baker's yeast or yeast)? If yes, please list:			
Have you ever had a serious reaction to any vaccination, including fainting and feeling dizzy?			
Have you ever had a health problem with lung, heart, kidney, or metabolic disease (e.g., diabetes), asthma, or a blood disorder? If yes, please list:			
Have you ever had a seizure disorder for which the patient is on seizure medication(s), a brain disorder, Guillain-Barre syndrome, (a condition that causes paralysis) or other nervous system problems?			
For women: Are you pregnant or considering becoming pregnant in the next month?			

COVID-19 VACCINES	Yes	No	N/A
Are you currently in quarantine due to an exposure to COVID-19?			
Are you currently in isolation due to being diagnosed with COVID-19 in the last 10 days?			
Have you received passive antibody therapy (monoclonal antibodies/convalescent serum) as treatment for COVID-19 in the last 90 days?			
Do you have a weakened immune system caused by something such as HIV, cancer, transplant, or do you take immunosuppressive drugs/therapies (e.g. steroid, chemotherapy, radiation)? Please specify:			
Have you ever received a COVID-19 vaccine? If yes, manufacturer of previous dose: _____ Date of last Covid Vaccine: _____			

OTHER QUESTIONS	Yes	No	N/A
Have you been told you have pre-diabetes?			
Are you interested in learning how to delay diagnosis of diabetes?			
MEDICARE PATIENTS			
Do you have a diagnosis of type 2 diabetes?			
Have you received a pair of diabetic shoes in the last year?			

Please turn over and complete signature and insurance information.

I certify that I am: (a) the patient and at least 18 years of age or (b) the parent or legal guardian of the patient. Further, I hereby give my consent to the healthcare provider of Shane's Pharmacy, to administer the vaccine(s) I have requested above. I understand the risks and benefits associated with the above vaccine(s) and have received, read and/or had explained to me the Vaccine Information Statements on the vaccine(s) I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless the applicable Provider, it's staff, agents, successors, divisions, affiliates, subsidiaries, officers, director, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above. I acknowledge that I understand the purposes/benefits of my State's Immunization registry ("State Registry") and the Provider may disclose my immunization information to the State Registry. I acknowledge that, depending upon my state's law, I may prevent the disclosure of my immunization information by the applicable Provider to the State Registry by using the opt-out form. The Provider will, if my state permits, provide me with an Opt-Out form. I understand that, depending on my state's law, I may need to specifically consent, and to the extent required by my state's law, by signing below, I hereby do consent to the Provider reporting my immunization information to the State Registry. I understand that even if I do not consent or if I withdraw my consent, my state's laws may permit certain disclosures of my immunization information as required or permitted by law. I voluntarily authorize and direct my healthcare provider at Shane's Pharmacy to use or disclose my health information during the term of this Authorization to the physician responsible for this protocol of specific health information of people vaccinated at Shane's Pharmacy, my Primary Care Physician, my insurance and/or state or federal registries, where required, for the purpose of treatment, payment or other healthcare operations. I further agree to be fully financially responsible for any cost sharing amounts, including copays, coinsurance, and deductibles, for the requested items and services as well as for any requested items and services not covered by my insurance benefits. I understand that any payment for which I am financially responsible is due at the time of service. By signing this form, I attest that all information I have provided on this form is true and accurate, thereby qualifying me to receive immunizations.

PATIENT NAME: _____
(Please print clearly)

PATIENT SIGNATURE: _____ **DATE:** _____
(Parent or guardian if minor)

INSURANCE INFORMATION

Rx BIN: _____ **Cardholder Name:** _____ **Cardholder Date of Birth:** _____

Rx PCN: _____ **ID #:** _____ **Medicaid #:** _____

RxGroup: _____ **Medicare #:** _____

PHARMACY USE ONLY

VACCINE(S) GIVEN

Vaccine	NDC	Manuf	Dose	VIS	Lot #	Exp. Date	Site and Route
<input type="checkbox"/> Influenza Inj. Fluarix	58160-0912-52	GSK	0.5ml	01/31/25			<input type="checkbox"/> LD <input type="checkbox"/> RD <input type="checkbox"/> IM
<input type="checkbox"/> Influenza Inj. Fluzone High Dose	49281-0125-65	Sanofi	0.5ml	01/31/25			<input type="checkbox"/> LD <input type="checkbox"/> RD <input type="checkbox"/> IM
<input type="checkbox"/> Pneumococcal Prevnar 20	00005-2000-02	Pfizer	0.5ml	05/29/25			<input type="checkbox"/> LD <input type="checkbox"/> RD <input type="checkbox"/> IM
<input type="checkbox"/> RSV Abrysvo	00069-0344-01	Pfizer	0.5ml	01/31/25			<input type="checkbox"/> LD <input type="checkbox"/> RD <input type="checkbox"/> IM
<input type="checkbox"/> Shingles Shingrix	58160-0823-11	GSK	0.5ml	02/04/22			<input type="checkbox"/> LD <input type="checkbox"/> RD <input type="checkbox"/> IM
<input type="checkbox"/> COVID-19 Moderna Spikevax	80777-0112-96	Moderna	0.5ml	01/31/25			<input type="checkbox"/> LD <input type="checkbox"/> RD <input type="checkbox"/> IM
<input type="checkbox"/> Tdap Boostrix	58160-0842-52	GSK	0.5ml	01/31/25			<input type="checkbox"/> LD <input type="checkbox"/> RD <input type="checkbox"/> IM
							<input type="checkbox"/> LD <input type="checkbox"/> RD <input type="checkbox"/> IM

PHARMACIST/INTERN SIGNATURE: _____ **ADMINISTRATION DATE:** _____