



IMMUNIZATION SCREENING AND CONSENT FORM

PATIENT INFORMATION

Last Name:	First Name:	MI:	DOB:	Age:	Gender:
Home Address:			Contact Phone:		
City:	State:	Zip Code:	County:		
Race (select one or more):			Ethnicity:		
<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other			<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino		
Primary Care Physician:			Physician Phone:		
Physician Address:			Physician Fax:		
Which vaccine(s) would the patient like to receive today?					
<input type="checkbox"/> Influenza (Injectable)	<input type="checkbox"/> Zoster (Shingles)	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> MMR		
<input type="checkbox"/> Influenza (Nasal)	<input type="checkbox"/> Td	<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Varicella		
<input type="checkbox"/> Pneumococcal	<input type="checkbox"/> Tdap	<input type="checkbox"/> Hepatitis A & B	<input type="checkbox"/> Hib		
<input type="checkbox"/> Meningococcal	<input type="checkbox"/> HPV		<input type="checkbox"/> Typhoid		

SCREENING QUESTIONNAIRE

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

ALL VACCINES	YES	NO	DON'T KNOW
Are you feeling sick or experiencing a moderate to high fever today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any allergies to medications, food (i.e. eggs), latex, vaccine component (e.g. neomycin, formaldehyde, gentamicin, thimerosal, bovine protein, phenol, polymyxin, gelatin, baker's yeast or yeast)? If yes, please list:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a serious reaction to any vaccinations, including fainting or dizziness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you take any anticoagulation (blood-thinning) medications (i.e. Warfarin, Eliquis, Xarelto), or are you on long-term Aspirin therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you, or a sibling or parent, ever had a seizure? Have you ever had a seizure disorder for which seizure medication(s) were prescribed? Have you ever had brain or other nervous system problems, such as Guillain-Barré Syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have cancer, leukemia, HIV/AIDS, or any other condition that weakens the immune system?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the past three months, have you taken medications that weaken your immune system such as cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
For women: Are you pregnant or considering becoming pregnant in the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



COVID-19 SCREENING	YES	NO	DON'T KNOW
In the past two weeks, have you tested positive for COVID-19 or are you currently being monitored for COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the past two weeks, have you had contact with someone who tested positive for COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LIVE VACCINES ONLY (CHICKEN POX, FLU NASAL SPRAY, MMR II, ORAL TYPHOID)	YES	NO	DON'T KNOW
Have you received any vaccinations or skin test within the past four weeks? <i>If yes, please list:</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently on home infusions or weekly injections (such as Remicade, Humira, Enbrel, Cimzia, Simponi, Simponi Aria, Xeljanz, Orencia, Arava, Actemra, Cytoxan, Rituxan, adalimumab, infliximab, or entanercept), or do you currently take high-dose methotrexate, azathioprine or 6-mercaptopurine, antivirals, anticancer drugs, or radiation treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you received a transfusion of blood or blood products, or have you been given a medication called immune (gamma) globulin in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently taking high-dose steroid therapy (Prednisone >20mg/day or equivalent) for longer than two weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FLU NASAL SPRAY ONLY (FLUMIST QUADRIVALENT)	YES	NO	DON'T KNOW
Are you receiving aspirin therapy or aspirin-containing therapy? (if 18 years and younger)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a nasal condition serious enough to make breathing difficult, such as a very stuffy nose? (FluMist only)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I certify that I am: (a) the patient and at least 18 year of age or (b) the parent or legal guardian of the patient. Further, I hereby give my consent to the healthcare provider of The Medicine Store, as applicable (each an applicable provider) to administer the vaccine(s) I have requested above. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). 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 questions were answered to my satisfaction. On behalf of myself, my heirs, and directors, I release The Medicine Store 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 voluntarily authorize and direct my healthcare provider at The Medicine Store 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 The Medicine Store, 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 payments for which I am financially responsible is due at the time of service or, The Medicine Store invoices me after the time of service, upon receipt of such invoice.

PATIENT NAME: _____
(PLEASE PRINT CLEARLY)

PATIENT SIGNATURE: _____ **DATE:** _____
(PARENT/GUARDIAN IF MINOR)