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*):
__American Indian or Alaska Native
__Asian
__Black or African American
__Native Hawaiian or Other Pacific Islander
__White
__Other

Ethnicity:
__Hispanic or Latino
__Not Hispanic or Latino

Primary Care Physician: **Physician Phone:**

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

☐ Influenza (Injectable)	☐ Zoster (Shingles)	☐ Hepatitis A	☐ MMR
☐ Influenza (Nasal)	☐ Td	☐ Hepatitis B	☐ Varicella
☐ Pneumococcal	☐ Tdap	☐ Hepatitis A & B	☐ Hib
☐ Meningococcal	☐ HPV		☐ 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?	☐	☐	☐
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:***	☐	☐	☐
Have you ever had a serious reaction to any vaccinations including allergic reaction, fainting or dizziness?	☐	☐	☐
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:***	☐	☐	☐
Do you take any anticoagulation (blood-thinning) medications (i.e. Warfarin, Eliquis, Xarelto), or are you on long-term Aspirin therapy?	☐	☐	☐
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?	☐	☐	☐
Do you have cancer, leukemia, HIV/AIDS, or any other condition that weakens the immune system?	☐	☐	☐
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?	☐	☐	☐
For women: Are you pregnant or considering becoming pregnant in the next month?	☐	☐	☐

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? If yes, you should be quarantining and should wait to receive any vaccine until the health department has confirmed that your quarantine period is over).	☐	☐	☐
Have you been vaccinated for COVID-19?	☐	☐	☐
In the past two weeks, have you had contact with someone who tested positive for COVID-19?			
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? If yes, you may consider getting tested for COVID-19 here at The Medicine Store before receiving your vaccine today.	☐	☐	☐

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: ____ **DATE OF BIRTH:______________**
(*PLEASE PRINT CLEARLY*)

PATIENT SIGNATURE or LEGAL GUARDIAN SIGNATURE: ___________________________________ **DATE:** ______________
(SIGNATURE MUST BE PARENT/GUARDIAN IF PATIENT IS A MINOR)

PRINT PARENT/LEGAL GUARDIAN NAME: ____
(ONLY NEEDS TO BE FILLED IN IF PATIENT IS A MINOR)