Medicare Part B Number: _____
Cash Paid Amt: $_____Insurance Number: _____

PROSPECTVILLE PHARMACY

Patient Consent & Release Form and Screening Questionnaire for Immunization

Section I. Personal information (Please print neatly.)

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

Age: _____ **Gender:** ___M ___F **List Medical Conditions:** _____

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

Phone Number and Email Address: _____ **Emergency Contact:** _____

Emergency Contact Person's Relationship and Number: _____

Primary Care Doctor:_____ **Doctor's Number:** _____

Doctor's Address: _____

Section II. Questionnaire for Immunization

		Please answer these questions by checking the boxes. If the question is not clear, please ask the pharmacist.	Yes	No	Don't Know
ALL	1.	Do you feel sick today?	0	0	0
	2.	Do you currently smoke?	0	0	0
	3.	Do you have an **allergy** to medications, foods or any vaccines? For Example: Eggs, Gelatin, Thimerosal, Neomycin, Gentamicin, yeast, or Latex	0	0	0
	4.	Have you ever had a reaction or fainted after receiving any vaccination?	0	0	0
	5.	**If you are over the age of 65:** Have you ever had a Pneumococcal vaccination?	0	0	0
	6.	I**f you are over the age of 50:** Have you ever had a Shingles vaccination?	0	0	0
	7.	**For women:** Are you pregnant or are you planning on becoming pregnant?	0	0	0
	8.	Do you take cortisone, prednisone, other steroids, or anticancer drugs, or, have you had X-ray treatments recently?	0	0	0
	9.	Do you have cancer, leukemia, HIV, blood disorders involving low platelet count, or any long term health condition (i.e. diabetes, asthma, other)? If yes, please specify:	0	0	0
	10.	Have you ever had a seizure disorder, brain disorder, or Guillain-Barre Syndrome?	0	0	0
MENING.	11.	Have you ever been diagnosed with sickle cell disease or a spleen disorder?	0	0	0
LIVE	12.	**Have you been diagnosed with any airway disease (asthma, COPD, or other)?**	0	0	0
	13.	Have you received any immunizations in the past 4 weeks? If yes, please specify:	0	0	0
	14.	During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin?	0	0	0

Section III. Influenza Information. For more vaccine info, refer to the appropriate VIS (i.e. Influenza, Pneumococcal, Shingles)

Inactivated Influenza Vaccine (injection) ages 6-months old and older: Created from a dead virus, the flu vaccine will not give you the flu. Injection is in the muscle. Some vaccines contain a preservative called thimerosal; thimerosal-free vaccines are available upon request. **Side effects** include soreness, redness, or swelling at the injection site. Fever, hoarseness, red or itchy eyes, fatigue, and muscle aches are also possible. These symptoms usually begin soon after the shot and last for one to two days. "High-dose" inactivated influenza vaccine available for people 65 years of age and older.

Live, Attenuated Influenza Vaccine (nasal spray) ages 2-49: Live but attenuated (weakened) virus that is sprayed into the nostrils. **Side effects** in children (ages 2-17 years of age) include runny nose, nasal congestion, cough, fever, wheezing, headache, muscle ache, and abdominal pain/occasional vomiting/diarrhea. Side effects are generally mild in adults and occur at low frequency. **Side effects** in adults (18-49 years of age) include runny nose/nasal congestion, cough, chills, tiredness/weakness, sore throat, and headache. These symptoms usually last up to a few days following administration of the vaccine.

Section IV. 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 (or Parent/Guardian, if Recipient is a Minor): _____

Print Guardian name and number (if Recipient is a Minor): _____**Date:** __

I have received a copy of the notice of Privacy Practices and appropriate CDC Vaccine Information Statement (VIS). I understand the notice of Privacy Practices provides an explanation of the ways in which my health information may be used or disclosed by the 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 and VIS: _____**Date** _____

Pharmacy Use Only:

Vaccine	Date(s) of Doses Administered	Vaccine Lot#	Expiration Date	MFR	Dosage	Injection Site(s)	VIS Date	Amt Paid
Influenza Shot or Intradermal								
Covid								
Influenza HD								
Pneumococcal								
Zoster (Shingles)								
Tdap or Td								
RSV								

Signature of Pharmacist or Nurse who administered the vaccine(s): _____ **Date** _____