IMMUNIZATION SCREENING AND CONSENT FORM

Family Health Care

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI	GENDER AT BIRTH (M/F)	DATE OF BIRTH

ADDRESS	CITY	STATE	ZIP

PATIENT'S PHONE #	PRIMARY CARE PROVIDER	PROVIDER PHONE/FAX

ETHNICITY: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

RACE: ☐ Native American/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black ☐White ☐ Unknown

MEDICARE PART B RECIPIENTS ONLY

I authorize FHC Pharmacy to release information and request payment. I certify that the information given by me in applying for payment under Medicare is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf to Part B Specialists as my Medicare Part B provider.

MEDICARE PART B? (Y/N)	IF YES, NAME AS IT APPEARS ON CARD	MEDICARE NUMBER

VACCINES REQUESTED

PLEASE LIST: _____

SAFETY SCREENING QUESTIONS

1.	Are you sick today?	☐**Yes** ☐**No**
2.	Do you have allergies to medications, food, or vaccine components (i.e., eggs, latex)? Please list: _____	☐**Yes** ☐**No**
3.	Have you ever had a serious reaction after receiving a vaccination?	☐**Yes** ☐**No**
4.	Have you ever fainted or felt dizzy after receiving a vaccination?	☐**Yes** ☐**No**
5.	Do you have a long-term health problem with heart, lung, kidney, or metabolic disease (i.e., diabetes), a blood disorder, no spleen or non-functioning spleen, complement component deficiency, a cochlear implant, spinal fluid leak, or take a blood thinning medication?	☐**Yes** ☐**No**
6.	Have you ever had a seizure disorder, brain disorder, Guillain Barre Syndrome, or other nervous system problem?	☐**Yes** ☐**No**
7.	Are you pregnant or is there a chance you could become pregnant in the next month?	☐**Yes** ☐**No**
8.	Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem or have a first degree relative with an immune system problem?	☐**Yes** ☐**No**
9.	In the past 3 months, have you taken medications that weaken your immune system such as prednisone, other steroids, anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or other autoimmune diseases; or have you had radiation treatments?	☐**Yes** ☐**No**
10.	During the past year have you received a transfusion of blood or blood products or been given immune (gamma) globulin or an antiviral drug?	☐**Yes** ☐**No**
11.	Have you received any vaccinations in the past 4 weeks?	☐**Yes** ☐**No**

FOR COVID-19 VACCINE ONLY:

12.	Have you ever received a dose of COVID-19 vaccine? If yes, **please indicate:** ☐Pfizer ☐Moderna ☐Janssen (Johnson & Johnson) ☐Novavax Other: _____	☐**Yes** ☐**No**
13.	Have you ever had an allergic reaction to a previous dose of the COVID-19 vaccine or a component (i.e., polyethylene glycol, polysorbate) of the vaccine? **If yes, what was your reaction**: _____	☐**Yes** ☐**No**
14.	Have you been diagnosed with COVID-19 within the past 3 months?	☐**Yes** ☐**No**
15.	Do you have a history of myocarditis or pericarditis, Multisystem Inflammatory Syndrome (MIS-C OR MIS-A), immune-mediated syndrome defined by thrombosis and thrombocytopenia such as heparin-induced thrombocytopenia, thrombosis with thrombocytopenia? If yes, please **circle.**	☐**Yes** ☐**No**

(CONTINUE ON BACK)

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PATIENT CONSENT

- I have been provided and have read the information sheet about the vaccination(s) I am receiving today.
- I have had an opportunity to review my answers to the questions above and ask questions that were answered to my satisfaction with the Family Health Care (FHC) Pharmacy's pharmacist.
- The information that I provided above is correct and true to the best of my knowledge.
- I agree to wait in the vaccination area for at least 15 minutes for observation by FHC Pharmacy's pharmacist.
- I certify that I am at least 18 years old or am the legal guardian and hereby give my consent to the staff of FHC Pharmacy to administer the vaccine(s) listed below.
- I understand that it is not possible to predict all possible side effects or complications associated with vaccines.
- I, on behalf of myself, my heirs, executors, personal representatives, agents, successors, and assignees hereby agree to release, indemnify, and hold harmless FHC Pharmacy, its affiliates, agents, officers, directors, contractors, and employees from any and all claims arising out of, in connection with, or in any way related to the administration of the vaccines listed below.
- I agree that FHC Pharmacy will notify my physician of vaccines received by entering vaccine information into the state immunization registry and/or providing documentation as required by state law and/or Board of Pharmacy rules and regulations.
- I understand that FHC Pharmacy can only bill certain insurances and that FHC Pharmacy will provide me with this receipt that can be submitted to my insurance company for possible reimbursement.
- It is my responsibility to work with my insurance company to resolve any issues with payment.

PATIENT/LEGAL GUARDIAN SIGNATURE: _____

PATIENT NAME (PRINTED): _____

ADMINISTRATION RECORD: PHARMACY USE ONLY

VACCINE:_____	SITE OF INJ:_____	**VACCINE**:_____	SITE OF INJ:_____	**VACCINE**:_____	SITE OF INJ:_____
LOT:_____	EXP. DATE:_____	LOT:_____	EXP. DATE:_____	LOT:_____	EXP. DATE:_____
RT OF ADMIN:_____	MFR:_____	RT OF ADMIN:_____	MFR:_____	RT OF ADMIN:_____	MFR:_____
VIS VERSION:_____	DOSAGE:_____	VIS VERSION:_____	DOSAGE:_____	VIS VERSION:_____	DOSAGE:_____

DATE OF VACCINATION/ DATE VIS GIVEN	IMMUNIZER/PHARMACIST SIGNATURE	IMMUNIZER NAME (PRINTED)

PLACE PHARMACY LABEL(S) / BACKTAG(S) HERE