IMMUNIZATION SCREENING AND CONSENT FORM

Family Health Care Pharmacy

PATIENT INFORMATION

AGE: ( )

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

ADDRESS | CITY | STATE | ZIP CODE

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

THE INFORMATION ABOVE IS CURRENT AND CORRECT: ☐ Yes ☐ No, I have provided corrections above

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 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, a vaccine component, or latex? PLEASE LIST:_____	Yes	No
3. Have you ever had a serious reaction after receiving a vaccination?	Yes	No
4. Do you have any of the following: a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak? Are you on long term aspirin therapy?	Yes	No
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	Yes	No
6. Do you have a parent, brother, or sister with an immune system problem?	Yes	No
7. In the past 6 months, have you taken medications that weaken your immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?	Yes	No
8. Have you had a seizure disorder, brain disorder, Guillain Barre Syndrome, or other nervous system problem?	Yes	No
9. Have you ever been diagnosed with a heart condition (myocarditis or pericarditis) or have you had Multisystem Inflammatory Syndrome (MIS-A or MIS-C) after an infection with the virus that causes COVID-19?	Yes	No
10. In the past year, have you received immune (gamma) globulin, blood/blood products, or an antiviral drug?	Yes	No
11. Are you pregnant?	Yes	No
12. Have you received any vaccinations in the past 4 weeks?	Yes	No
13. Have you ever felt dizzy or faint before, during, or after a shot?	Yes	No
14. Are you anxious about getting a shot today?	Yes	No

(CONTINUE ON BACK)

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 vaccinaton 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 releated to the adminstration of the vaccine(s) 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:_____ **DATE:**_____

PATIENT NAME (PRINTED): _____

ADMINISTRATION RECORD: PHARMACY USE ONLY

Vaccine 1	Manufacturer	Lot	Exp Date	Dose	Site of Injection	Date of VIS
					LD RD	
		Place syringe or vial sticker here				
Vaccine 2						
					LD RD	
		Place syringe or vial sticker here				

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

INITIALS

Prior to Administration

_____ RPh Checked-Ready to Administer

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

After Administration

_____ Confirmed Admin info matches Pioneer

_____ Ready to Scan

_____ Scanned, Ready to File

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