SCOTT DRUG PHARMACY
IMMUNIZATION SCREENING AND CONSENT FORM

PATIENT INFORMATION (Please print clearly)

Last Name:	First Name:	MI:	D.O.B:	Age:
Race/Ethnicity:			Gender:	
Home Address:			Contact Phone:	
City:		State:	Zip:	
Primary Care Physician:				

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

Influenza	Shingles (Shingrix): 1st __ 2nd __	Meningococcal	MMR
Pneumococcal	Tdap	RSV	Covid

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 today? If yes, please circle if you are experiencing any of the following: fever cough diarrhea vomiting			
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 fainting and feeling dizzy?			
Have you ever had a health problem with lung, heart, kidney, liver or metabolic disease (e.g., diabetes), neurological or neuromuscular disease, asthma, anemia or another blood disorder? If yes, Please list:			
Have you ever had a seizure disorder for which the patient is on seizure medication(s), a brain disorder, Guillain-Barre Syndrome (a condition that causes paralysis) or other nervous system problem?			
Has any physician or other healthcare professional ever cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a physician's office or hospital?			
For Tdap only: Do you have an open wound, puncture or tissue tear that prompted you to get a tetanus shot?			
For women only: Are you pregnant or considering becoming pregnant in the next month?			

HAS THE PATIENT HAD THE FOLLOWING VACCINES:			
Pneumococcal Vaccine			
Shingles Vaccine			
Tdap (Whooping Cough) Vaccine			

I certify that I am: (a) the patient and at least 18 years of age or (b) the parent or legal guardian of the patient. Further, I hereby give my consent to the healthcare provider of SCOTT DRUG PHARMACY to administer the vaccine(s) I have requested above. 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 such questions were answered to my satisfaction. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless the applicable Provider, its staff, agents, successors, division, affiliates, subsidiaries, officers, directors, 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 acknowledge that I understand the purposes/benefits of my state's immunization registry ("State Registry") and the Provider may disclose my immunization information to the State Registry. I acknowledge that, depending upon my state's law, I may prevent the disclosure of my immunization information by the applicable Provider to the State Registry by using the op-out form. The Provider will, if my state permits, provide me with an Opt-Out Form. I understand that, depending on my state's law, I may need to specifically consent, and to the extent required by my state's law, by signing below, I hereby do consent to the Provider reporting my immunization information to the State Registry. I understand that even if I do not consent or if I withdraw my consent, my state's laws may permit certain disclosures of my immunization information as required or permitted by law. I voluntarily authorize and direct my healthcare provider at SCOTT DRUG PHARMACY to use or disclose my health information during the term of the Authorization to the physician responsible for this protocol of specific health information of people vaccinated at SCOTT DRUG PHARMACY, 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 deductible, 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 payment for which I am financially responsible is due at the time of service.

PATIENT NAME: _____
(Please print clearly)

PATIENT SIGNATURE: _____**DATE**: _____
(Parent or guardian, if minor)

PHARMACY USE ONLY

Vaccine	NDC	Manufacturer	Dose	Lot #	Exp. Date	Site of Admin	Route of Admin
Influenza						LA RA	IM
Shingles						LA RA	IM
Pneumococcal						LA RA	IM
Meningococcal						LA RA	IM
Tdap						LA RA	IM
MMR						LA RA	IM
Covid						LA RA	IM
RSV						LA RA	IM

PHARMACIST/INTERN SIGNATURE: _____

ADMINISTRATION DATE: _____ **DATE VIS GIVEN TO PATIENT:** _____**VIS DATE:**_____