Vaccine Screening Questionnaire and Consent Form

Patient Name_________________________________ Date of Birth____________ Gender F M

Address __________________________________City__________________ZIP_________ Phone__________________

Which vaccines would you like to receive today? ☐ Covid-19 ☐Shingles ☐ Influenza ☐Pneumococcal ☐Tdap ☐Hepatitis A ☐Hepatitis B ☐Typhoid ☐ Meningococcal

Medicare ID _________________________ Kancare ID__________________________

Insurance information: Id number______________________Bin_________PCN_________Group_________

The following questions will help us determine which vaccines you may be given today. If you answer "yes" to a question, it does not mean you should not be vaccinated. It just means additional questions may be asked. If a question is unclear, please ask the pharmacist to explain it.

	Question	Yes	No
1.	Are you sick today or experiencing a high fever	☐	☐
2.	Do you have allergies to medications, polysorbate, vaccine components, or latex? Use an Epipen?	☐	☐
3.	Have you ever had a serious reaction after receiving a vaccination?	☐	☐
4.	Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease, anemia, or any other blood disorder?	☐	☐
5.	Are you currently taking a blood thinner?	☐	☐
6.	Do you have cancer, leukemia, HIV/AIDS, or a weakened immune system?	☐	☐
7.	Have you had a seizure or a brain or other nervous system disorder?	☐	☐
8.	Have you received passive antibody therapy as a treatment for COVID-19 ?	☐	☐
9.	Are you pregnant or breast feeding?	☐	☐
10.	Have you received any vaccinations in the past 4 weeks?	☐	☐
11.	Have you tested positive for or have a test pending for COVID-19?	☐	☐

12. How many COVID-19 immunizations have you had? ____ which vaccine? _________________
13. What is your age? ______ other vaccines you are interested in? _________________

I have read, or have read to me, the information regarding the vaccine marked above. I have had an opportunity to ask questions that were answered to my satisfaction. I understand the benefits and the risks of the vaccine. I consent for my information to be released to the appropriate agencies. I consent to, or give consent for, the administration of the vaccine marked above to:

Signature of vaccine recipient ____ Date_________________
(or guardian if under 18 years old)

Form reviewed by____ Date_______________________

VIS/EUA date____________ ☐Scanned as RX

Site of vaccination L R ☐Notified PCP

Manufacturer__________ ☐WEBIZ

Lot number/Exp date ___________ ☐RCHD

1st 2nd 1ST booster 2ND booster

Notification of Vaccination

Dear Doctor_______________________: Fax______________________

I have recently provided a vaccination to one of your patients. A personal immunization record was filled out and given to the patient. I want to make sure that you also have this information in order to update the patient's medical record. Please contact me if you have any questions about this information.

Patient__________________________________ **DOB**______________

The vaccination that was given on _____________ is checked below.

Vaccine

- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Influenza
- ☐ Meningococcal
- ☐ Pneumococcal
- ☐ Tdap
- ☐ Shingles

Megan Hedden PharmD
Von Bolton PharmD

Dunne's Pharmacy
2429 Claflin Rd
Manahattan KS 66502

Confidentiality Notice: The document in this transmission may contain confidential information belonging to the sender which is legally privileged. The information is intended only for the use of the individual named above. If you are not the intended recipient, you are herby notified that any disclosure, copying, distribution or taking of any action in reliance on the content of this information is strictly prohibited. If you received this in error please notify us by telephone (785)539-2345 to arrange for the return of the original document. Thank you