VACCINE CONSENT AND SCREENING FORM

PATIENT INFORMATION

Full Name:

_____

Date of Birth:

_____

Gender:

_____

Address:

_____

Phone:

_____

Email

_____

Which vaccine are you here for?: Name and fax number of doctor to notify (Optional):

_____

SCREENING QUESTIONS

Question	Yes / Sí	No
1. Are you feeling sick today?		
2. Any allergies to food, medicine, latex, or vaccines?		
3. Serious reaction to a vaccine in the past?		
4. Fainting with vaccines or blood draws?		
5. Bleeding disorder or blood thinners?		
6. Received a vaccine in the last 4 weeks?		
7. Immunocompromised or taking immunosuppressive meds?		
8. Pregnant or breastfeeding?		
9. Positive COVID-19 test in the last 14 days?		

CONSENT FOR VACCINATION

Consent to share vaccine record with state registry NJIIS: (Circle one): Yes No No

I have received and read the Vaccine Information Statement (VIS) or EUA Fact Sheet. I understand the risks and benefits and give my consent to receive the vaccine or have it administered to the individual named above for whom I am authorized to sign.

Signature of Patient/Parent/Guardian: _____ Date: _____

VACCINE INFORMATION (pharmacist will fill details below)

Product	Lot Number	Expiration Date	Route/Site	Administered By	Date & Time

Hightstown Pharmacy
100 Main St, Hightstown, NJ 08520
(609) 371-9000