Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_ Gender (circle one): Male / Female

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Screening Questions (if you answer yes, please explain below) Please circle

|  |  |  |
| --- | --- | --- |
| 1. Do you have medical insurance? If yes please show card to pharmacist. 2. Are you sick today? | Yes  Yes | No  No |
| 1. Do you have allergies to medications, food, a vaccine component, or latex? | Yes | No |
| 1. Have you ever had a serious reaction after receiving a vaccination? | Yes | No |
| 1. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder? | Yes | No |
| 1. Do you have cancer, leukemia, AIDS, or any other immune system problem? | Yes | No |
| 1. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments? | Yes | No |
| 1. Have you had a seizure or a brain or other nervous system problem? | Yes | No |
| 1. 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 |
| 1. For women: Are you pregnant or is there a chance you could become pregnant during the next month? | Yes | No |
| 1. Have you received any vaccinations in the past 4 weeks? | Yes | No |

**Consent and waiver:** I consent to the staff to administer the medication(s) mentioned below. I have reviewed the vaccine information sheet (s) and understand the benefits and risks of receiving this medication and choose to assume this risk. I fully release and discharge the **standing order physician)** and the pharmacy, its affiliations and their officers, and employees from any illness, injury, loss, or damage that may result there from. I acknowledge that ***I have received a copy of the pharmacy’s privacy policies according to HIPPA***. I assign payment of authorized insurance benefits due to me to be paid to the pharmacy and will pay any copay or deductible that result. I consent the release of medical information when necessary for billing, reimbursement, and medical protocol. I also allow for the pharmacy to report any medications received to the appropriate state vaccine registry. I am aware that an immunization certified student pharmacist might be administering this medication.  **I agree to wait near the vaccination area for approximately 20 minutes to receive treatment in case of adverse reaction.**

Signature of patient X:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Below is for pharmacy documentation

Medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ VIS Date: \_\_\_\_\_\_\_\_ Lot #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exp Date: \_\_\_\_\_\_\_\_ Site: \_\_\_\_

Medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ VIS Date: \_\_\_\_\_\_\_\_ Lot #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exp Date: \_\_\_\_\_\_\_\_ Site: \_\_\_\_

Administered by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Given:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_