Vaccine Administration Record, Screening and Patient Consent

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____ Phone: _____

Primary Care Physician (PCP): _____ PCP Phone: _____

PCP Address: _____

1) Have you ever had a severe reaction to any vaccine requiring medical attention? If yes, please describe:	YES	NO
2) Are you allergic to eggs, thimerosal mercury, neomycin or gelatin?	YES	NO
3) Are you sick or running a fever?	YES	NO
4) Have you had Guillain-Barre syndrome, seizures, brain or nerve problems?	YES	NO
5) Are you pregnant or planning to become pregnant in the next 3 months?	YES	NO
6) Are you, or anyone in your household, being treated with chemotherapy or radiation for cancer, have HIV/AIDS or any other immune deficiency disorder?	YES	NO
7) Are you, or anyone in your household, taking oral prednisone (>20mg/day), other oral steroids or anticancer drugs?	YES	NO
8) Do you have a bleeding disorder or take "blood thinners" like Coumadin or heparin?	YES	NO
9) Have you received any vaccine within the last 4 weeks?	YES	NO
10) Do you smoke, have chronic lung conditions such as COPD or asthma, diabetes, kidney or liver disorders or sickle cell disease? If yes: Have you ever received a pneumonia vaccine?	YES YES	NO NO
11) Was your latest tetanus booster within the last 10 years?	YES	NO
12) Are you over the age of 50? If yes: Have you received a SHINGLES VACCINE?	YES YES	NO NO

Please read the following statements and sign below on the signature line:

I have read or have had explained the information provided about the vaccine I am about to receive. I have had an opportunity to ask questions that were answered to my satisfaction. I believe I understand the benefits and risk of vaccination and ask that the vaccine be given to me or to the person named above for whom I am authorized to make this request. I do hereby authorize West Wichita Family Pharmacy to release information and request payment from Medicare or commercial insurance. I certify that the information given by me in applying for payment is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf. I consent to inclusion of this immunization data in any state immunization registry for myself or on behalf of the person named below.

X_____ Date: _____

(Signature of person receiving vaccine or legal guardian if under 18 years old)

INTERNAL USE ONLY

Vaccine	Site	R or L	VIS Date	VIS Given	Lot #	Manufacturer	Exp. Date	Vaccinator

AFFIX HARD COPY STICKER AND VACCINE LABELS HERE

☐ Scanned asRx

☐ Notified PCP
Fax #

☐ Put in Medical Chart

☐ Document instate registry