IMMUNIZATION SCREENING AND CONSENT FORM

PATIENT INFORMATION

(Please print clearly)

Last Name: **First Name:** **MI:** **DOB:** **Age:** **Gender:**

Home Address: **Contact Phone:**

City: **State:** **Zip:**

Primary Care Physician:

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

☐ Influenza (Injectable)	☐ Pneumococcal **Select one:**	☐ Meningococcal
☐ HPV	☐ Pneumovax ☐ Prevnar	☐ Tdap
☐ Zoster (Shingles)	☐ Capvaxive	☐ MMR
☐ RSV	☐ COVID-19	☐ Other: _____

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: new fever, cough, diarrhea, vomiting	☐	☐	☐
Do you have any allergies to medications, food (e.g. eggs or egg products), latex, vaccines, or 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 any 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), neurologic or neuromuscular disease, asthma, anemia, or another blood disorder?	☐	☐	☐
Have you ever had a seizure disorder for which you are 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 women only: Are you pregnant or considering becoming pregnant in the next month?	☐	☐	☐
For Tdap or adult Td only: Do you have an open wound, puncture, or tissue tear that prompted you to get a tetanus shot?	☐	☐	☐

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 Perrone Pharmacy, Inc., 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 Statement(s) 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, divisions, 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 opt-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 information of people vaccinated at Perrone Pharmacy, Inc., 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 deductibles, 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 _____

PATIENT SIGNATURE _____ **DATE** _____

(Parent or guardian if minor)

Copies of insurance cards are needed for:

Medicare Part B

and

Medicare Part D

Place vial labels below :

PHARMACIST/INTERN SIGNATURE: _____

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