

VACCINATION SCREENING AND CONSENT FORM

Section 1: Patient Information

Name _____ DOB: _____

Street Address _____ Zip _____

Cell (____) _____ Email _____

I give permission to Sewall's Point Pharmacy, Inc to **contact me via text and or email** for prescription notifications, health related information updates, and promotions/newsletters.

Gender: Male Female Notes: _____

Drug/Food Allergies: _____

Emergency Contact person:

Relation

Tel

******Please present insurance or MEDICARE ID card for us to scan******

Section 2: Screening Questions

		YES	NO
ALL VACCINATIONS	1. Are you allergic to food/drugs, vaccines, vaccine components (neomycin, formaldehyde, gentamicin, thimerosal, bovine protein, phenol. Polymyxin, gelatin, yeast, polyethylene glycol, polysorbate)		
	2. Have you had a reaction after getting vaccines such as fainting, dizziness, light-headed, etc.?		
	3. Are you currently sick? For example, are you currently experiencing fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, etc.?		
	4. Are you immunocompromised (HIV/Cancer) or are you on a chronic medicine that affects your immune system? <i>*Advisory: people who are immunocompromised might be at increased risk for severe COVID-19 infections and have the potential for reduced immune responses.</i>		
	5. Do you have a bleeding disorder or take blood thinners?		
	6. Have you been diagnosed with Multisystem Inflammatory Syndrome in adults or children in the last 90 days?		
	7. Have you ever been diagnosed with Guillain-Barré syndrome?		
	8. Do you have a seizure, brain, or nerve problem?		

		YES	NO
LIVE VACCINATIONS ONLY (MMR, VARICELLA, ROTAVIRUS, INTRANASAL INFLUENZA)	1. Are you immunocompromised (HIV/Cancer) or are you on a chronic medicine that affects your immune system such as high-dose steroids, or cancer treatment with radiation or drugs?		
	2. Do you live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation?		
	3. During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin?		
	4. Are you immunocompromised (HIV/Cancer) or are you on a chronic medicine that affects your immune system? <i>*Advisory: people who are immunocompromised might be at increased risk for severe COVID-19 infections and have the potential for reduced immune responses.</i>		
	5. . Have you received any vaccinations in the past 4 weeks?		
	6. Have you been diagnosed with Multisystem Inflammatory Syndrome in adults or children in the last 90 days?		
	7. Do you have a long-term health problem such as heart, lung, kidney, liver, or metabolic disease (e.g., diabetes), neurologic or neuromuscular disease, anemia or other blood disorder?		
	8. For women: Are you pregnant/is there a chance you could become pregnant during the next month?		

Section 3: Consent for Vaccination

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 Sewall's Point 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 Statements 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 provider at Sewall's Point Pharmacy, Inc to use or disclose my health information during the term of this Authorization to the physician responsible for this protocol of specific health information of people vaccinated at Sewall's Point 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.

Print Name _____ Date _____

Signature _____ Relation to Patient Self Guardian/Parent
 Legal Representative

Section 4: Vaccination Record (pharmacy use only)

FOR ADMINISTRATIVE USE ONLY

Vaccine	Dose	Route	Date Administered	Vaccine Manufacturer / Lot/ Exp / VIS Date	Name of Vaccine Administrator
<input type="checkbox"/> Influenza <input type="checkbox"/> Zoster <input type="checkbox"/> Tdap <input type="checkbox"/> Pneumococcal <input type="checkbox"/> Other: _____	<input type="checkbox"/> 0.5 ml <input type="checkbox"/> Other: _____ ml	IM - L DELTOID IM - R DELTOID IM-OTHER: _____			<input type="checkbox"/> ABBEY BUCKMAN <input type="checkbox"/> JAE FORD <input type="checkbox"/> CRISTAL TOTTERMAN

Administrator Signature _____ Date _____

