Immunization Screening Questionnaire & Consent Form

(BUSINESS USE)

Patient Information: (Please Print)*

*Gender (circle one) M or F

*Patient Name: _____*Date of Birth: _____ *Age: _____ *Phone# _____

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

***For Emergency Use Only**

*Primary Care Physician (PCP):_____ *Dr. Phone number: _____

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

***Prescription Insurance**

Company:	ID#:	Rx Group#:
Rx Bin#	PCN#:	Relation:

***Payment Information (Assignment of Benefits and Responsibilities for Payment):** *This allows us to bill your health plan or company and receive payment directly. It also means that you agree to pay for services not covered by your health plan.* I authorize this health provider to bill my health plan or other payers on my behalf, and to receive direct payment of authorized benefits. I agree that it is my responsibility to pay for any health care services not covered by my health plan or company, including but not limited to copayments, deductibles and co-insurance.)

☐ Option 1 (Cash or Check)	☐ Option 2 (Credit/Debit Card)
If you selected **Option 2**, please complete the following: ☐ Visa ☐ Mastercard ☐ American Express	
CC#: Exp: Sec Code:	

The following questions will help us determine which vaccines may be given today. If a question is not clear, please ask the pharmacist.	**Yes**	**No**	**Don't Know**
Are you **sick today**?			
Do you have a long term health problem with heart disease, kidney disease, metabolic disorder (e.g. diabetes), anemia or other blood disorders?			
Do you have a long term health problem with lung disease or asthma? Do you smoke?			
Do you have allergies to medications, food (e.g. eggs), latex or any vaccine component (e.g. neomycin, formaldehyde, gentamicin, thimerosal, bovine protein, phenol, polymyxin, gelatin, baker's yeast or yeast?			
Have you received any vaccinations in the past 4 weeks?			
Have you ever had a **serious reaction** after receiving a vaccination?			
Do you have a neurological disorder such as seizures or other disorders that affect the brain or have had a disorder that resulted from a vaccine (e.g. Guilain-Barre Syndrome)?			
Do you have **cancer, leukemia, AIDS,** or any other immune system problem?			
Do you take prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?			
During the past year, have you received a transfusion of blood or blood products, including antibodies?			
For women: Are you pregnant or could you become pregnant in the next three months?			
Have you had the following vaccines:	**Yes**	**No**	**Don't Know**
Pneumococcal Vaccine			
Shingles Vaccine ☐ Zostavax ***OR*** ☐ Shingrix — Date of Administration:			
Whooping Cough (Tdap) Vaccine			

*I would like a copy of the vaccine information statement for my records. **Yes ___ No ___**

*I am aware the pharmacist will send copies of my vaccine documents to my primary care provider. **Yes ___ No ___**

*I have read, or have had explained to me, the information contained in the Vaccine Information Statement(s) regarding the vaccine(s) to be administered today. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the specific vaccine(s) and I ask that the vaccine(s) be given to me, or to the person for whim I am authorized to make this request. I also authorize Stark Pharmacy to release my immunization information record, or the immunization record of the person for whom I am authorized to make this request, to appropriate personnel or other health care provider(s) as needed.

*Vaccine Recipient Signature **X** Date

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Pharmacy Use Only

1. Diluent for: Lot # _____ Exp. Date: _____ Manufacturer: _____	**9. IPV** Lot # _____ Exp. Date: _____ Manufacturer: _____
2. DTaPL Lot # _____ Exp. Date: _____ Manufacturer: _____	**10. Meningococcal** Lot # _____ Exp. Date: _____ Manufacturer: _____
3. Hepatitis A Lot # _____ Exp. Date: _____ Manufacturer: _____	**11. MMR** Lot # _____ Exp. Date: _____ Manufacturer: _____
4. Hepatitis B Lot # _____ Exp. Date: _____ Manufacturer: _____	**12. Pneumococcal** Lot # _____ Exp. Date: _____ Manufacturer: _____
5. Hepatitis A & B Lot # _____ Exp. Date: _____ Manufacturer: _____	**13. Td** Lot # _____ Exp. Date: _____ Manufacturer: _____
6. Hib Lot # _____ Exp. Date: _____ Manufacturer: _____	**14. Tdap** Lot # _____ Exp. Date: _____ Manufacturer: _____
7. HPV Lot # _____ Exp. Date: _____ Manufacturer: _____	**15. Zoster (Shingles)** Lot # _____ Exp. Date: _____ Manufacturer: _____
8. Influenza Injection Lot # _____ Exp. Date: _____ Manufacturer: _____	**Injection#_____ Dosage: _____** Site: IM/Subq **R or L** Delt**.** (circle one) **Injection#_____ Dosage: _____** Site: IM/Subq **R or L** Delt**.** (circle one) **Injection#_____ Dosage: _____** Site: IM/Subq **R or L** Delt**.** (circle one)

Authorizing Physician: Douglas Cochran, MD 4320 Wornall Rd Kansas City, MO 64111 Phone: 816-932-6100/ Fax: 816-932-9002 DEA#:BC2182614 NPI#:1144229261	Pharmacist who administered vaccine(s) to patient: Ernest Rupp, R.Ph Pharmacist/Certified Immunizer Pharmacist Signature **X**