MediCenter Pharmacy Vaccine & Immunization Administration Record, Screening Questionnaire and Consent

Name: _____ DOB: ____/____/____ Gender: M/F Phone: (____) ____ - _____

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

Food/Drug Allergies: _____

Primary Care Physician: _____ Physician Address: _____

Medicare Part B: Y/N If yes, name as it appears on card: _____

Screening Questionnaire for Immunizations & Vaccinations

Please place a X in the box to help determine if the vaccine/immunization(s) may be given today

		YES	NO
1.	Are you sick today? (Do you have fever, diarrhea, or have you vomited?)		
2.	Have you had a server reaction to any vaccine?		
3.	Do you have allergies to medications, food (eggs), baker's yeast, thimerosal, streptomycin, neomycin or latex?		
4.	Are you pregnant or is there a chance you could become pregnant in the next month?		
5.	Have you had seizure disorder, brain disorder, neurological disorder or Gullian-Barre syndrome?		
6.	Do you have any other chronic health conditions like Asthma, diabetes or diseases of the heart, lungs or kidneys?		
7.	Have you had a pneumococcal or shingles vaccine?		
8.	Have you ever been vaccinated for Hepatitis A, B or started the series of Hepatitis A, B, or A & B?		
9-12 For Live Vaccines Only			
9.	Have you had a blood transfusion or received blood products such as immune globulin in the last year?		
10.	Have you received any vaccinations in the last 4 weeks?		
11.	Do you or another member of your household have cancer, leukemia, HIV/AIDS, or other immune system problems?		
12.	Are you currently on home infusions, weekly injections, steroid therapy, anticancer drugs or radiation treatment?		

Vaccine/Immunization Requested: **Flu** **Shingles** **Pneumonia (PCV13 or PPSV23)** **Meningococcal**

Hepatitis A **Hepatitis B** **Tetanus** **Diphtheria** **Pertussis** **Tdap**

I have read, or have had explained to me, the information regarding the vaccine(s)/immunizations(s) marked above. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) being administered and authorize the administration of the vaccine to me or the persons named below for who I am authorized to make the decision.

I, for myself, my heirs, and executors release MediCenter Pharmacy as the Medicare provider, any retail or external site, physician, and employees, from any and all claims arising out of or in a way related to my receipt of this or these immunizations(s). MediCenter Pharmacy and the aforementioned related parted shall not at any time or any extent be liable or responsible for any loss, injury, death or damage to be suffered or sustained at any time as a result of this vaccination program. I consent the release of this information to my Primary Care Physician as listed above to document receipt of vaccination**. I agree to wait in the vaccination location for approximately 15 minutes for observation after the vaccination.**

Acknowledgement of Notice of Privacy Practices: I have received a notice of privacy practices. I understand that this document provides an explanation of ways in which my health information may be used or disclosed by MediCenter Pharmacy and of my rights with respect to health information. I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.

☐ *I authorize MediCenter Pharmacy to release information and request payment. I certify that the information given by me in applying for payment under Medicare 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 to MediCenter Pharmacy as my Medicare Part B Provider:*

Signature: _____ Dates: _____

For Pharmacy Use Only

Vaccine Name	Mfg	Quantity (mL)	Lot #	Exp Date:	Injection Site/Route	Date Immunization/ Vis Given	Date on Vis	Date sent/method PCP	Date method Protocol Physician	Rph Initials

Adverse Reaction/Notification: _____