

**Screening Checklist and Consent Form for Inactivated Vaccines**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_AGE: \_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **Please answer the following Questions:** | **Y** | **N** | **?** |
| Are you sick today? |  |  |  |
| Do you have allergies to medications, food, latex, or any vaccines? |  |  |  |
| Have you ever had a serious reaction or fainted after receiving a vaccination? |  |  |  |
| Do you currently smoke? |  |  |  |
| Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem? |  |  |  |
| **If over the age of 65**: Have you ever had a pneumococcal vaccine? |  |  |  |
| **If over the age of 50:** Have you ever had a Shingles Vaccination? |  |  |  |
| **For women**: Are you pregnant or planning on becoming pregnant? |  |  |  |
| Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had X-ray treatments recently? |  |  |  |
| Do you have cancer, leukemia, HIV, blood disorders involving low platelet count, or any long-term health condition (i.e. diabetes, asthma, other)? If yes, please specify: |  |  |  |
| Have you ever had a seizure disorder, brain disorder, or Guillain-Barre Syndrome? |  |  |  |
| Have you ever been diagnosed with sickle cell disease or a spleen disorder? (**Meningitis Vaccine)** |  |  |  |

**Insurance Information:**

RXBIN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ RXPCN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RX Group: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicare ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I understand the benefits and risks of the vaccination(s) as described in the Vaccine Information Statement (VIS), a copy of which was provided with this Consent and Release, and I request the vaccine(s) be given to me.**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Vaccine Given** | **Lot/Exp** | **Date Given** | **Dosage** | **Injection Site** | **VIS Given** |
|  |  |  |  | **LD RD** |  |
|  |  |  |  |  |   |

**Signature of Pharmacist, Nurse, or Pharmacy Technician who administered the vaccine(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**