

Medicare Part B Number: _____ AMOUNT PAID \$ _____

Patient Consent and Release Form and Screening Questionnaire for Immunization

BIN _____ PCN _____ Member ID _____ rxGROUP _____

Patient's Full Name _____ Date of Birth: _____ M/F

Address: _____ City: **STL** State **MO** Zip Code: _____

Phone Number : _____ Emergency Contact: _____

Section II. Questionnaire for Immunization

		Please answer these questions by checking the boxes. If the question is not clear, please ask the pharmacist.	Yes	No	Don't Know
ALL	1.	Do you feel sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	2.	Do you have an allergy to medications, foods or any vaccines? For Example: Eggs, Gelatin, Thimerosal, Neomycin, Gentamicin, or Latex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	3.	Have you ever had a reaction or fainted after receiving any vaccination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	4.	If you are over the age of 65: Have you ever had a Pneumococcal vaccination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	5.	If you are over the age of 50: Have you ever had a Shingles vaccination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	6.	For women: Are you pregnant or are you planning on becoming pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	7.	Do you take any of the following "TNF Blockers" for the treatment of rheumatoid arthritis: etanercept (Enbrel), rituximab, adalimumab (Humira), or infliximab?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section III. Influenza Information. For other vaccines, (i.e. Pneumococcal, Shingles, Tdap), refer patient to the appropriate VIS

Inactivated Influenza Vaccine (injection) ages 6-months old and older: Created from a dead virus, the flu vaccine will not give you the flu. Injection is in the muscle. Some vaccines contain a preservative called thimerosal; thimerosal-free vaccines are available upon request. **Side effects** include soreness, redness, or swelling at the injection site. Fever, hoarseness, red or itchy eyes, fatigue, and muscle aches are also possible. These symptoms usually begin soon after the shot and last for one to two days. "High-dose" inactivated influenza vaccine available for people 65 years of age and older.

Section IV. Signatures

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. I request the vaccine(s) be given to me or to the person named below, a minor for whom I represent that I am authorized to sign this Consent and Release.

Signature of Person to Receive Vaccine (or Parent/Guardian, if Recipient is a Minor): _____

I have received a copy of the notice of Privacy Practices and appropriate CDC Vaccine Information Statement (VIS). I understand the notice of Privacy Practices provides an explanation of the ways in which my health information may be used or disclosed by the Pharmacy and of my rights with respect to my health information. I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.

Signature of Acknowledgment of Notice of Privacy Practices and VIS: _____ **Date** _____ -

Pharmacy Use Only

Vaccine	Date Administered	Vaccine Lot#	Expiration Date	MFR	Dosage	Injection Site	VIS Date	Amt Paid

Signature of Pharmacist who administered vaccine(s): _____ Date: _____

M L Schmittgens, RPh