

VACCINE SCREENING & CONSENT FORM

Patient Name: _____	DOB: _____ Age: _____
Address: _____	Apt/Unit: _____
Phone #: _____	Email: _____
Race: _____	Gender Assigned at Birth: ☐ Male ☐ Female
VACCINE(S) BEING RECEIVED TODAY	

Please check all that apply: ☐ Influenza ☐ COVID-19 ☐ Pneumonia ☐ RSV ☐ Shingles ☐ Tdap ☐ Meningitis ☐ Hepatitis B ☐ HPV ☐ Other: _____

VACCINE SCREENING QUESTIONS

The following questions help us determine which vaccines may be appropriate for you today. Answering “Yes” does not necessarily mean you should not be vaccinated. It may mean your healthcare provider needs to ask additional questions. If a question is unclear, please ask your healthcare provider.

Screening Question	YES	NO	DON'T KNOW
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 vaccine?	☐	☐	☐
Do you currently smoke?	☐	☐	☐
Do you have a long-term healthcare condition such as asthma, COPD, diabetes, heart disease, hypertension, kidney disease, liver disease, are immunosuppressed, or another condition?	☐	☐	☐
Have you had a seizure or a brain or other nervous system problem, including Guillain-Barré Syndrome (GBS)?	☐	☐	☐
For women: Are you pregnant?	☐	☐	☐
If age 50 or older: Have you ever had a shingles vaccination?	☐	☐	☐
If age 60 or older: Have you received the RSV vaccine?	☐	☐	☐
If over age 65: Have you ever received a pneumococcal vaccine?	☐	☐	☐
For COVID-19 vaccine: Has it been at least two (2) months since your last dose of COVID-19 vaccine?	☐	☐	☐
For COVID-19 vaccine: Do you have a history of myocarditis or pericarditis?	☐	☐	☐
For COVID-19 vaccine: Do you have a history of Multisystem Inflammatory Syndrome (MIS-C or MIS-A)?	☐	☐	☐
For COVID-19 vaccine: Have you been diagnosed with COVID-19	☐	☐	☐

disease within the past 3 months, or are you still experiencing symptoms?			
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PATIENT ACKNOWLEDGMENT & CONSENT

I have read, or have had read to me, the written information regarding the vaccine(s) being administered. I have had the opportunity to ask questions, and my questions have been answered to my satisfaction. I understand the benefits and risks of the vaccine(s) being administered and have received a copy of the current Vaccine Information Statement (VIS). I request that the vaccine(s) be administered to me or to the person named above for whom I am authorized to make this request. If, for some reason, my insurance plan does not cover the cost and/or administration of the vaccine by a pharmacist, I understand that I will be responsible for the cost of the vaccine and administration.

Signature of Patient, Guardian, or POA: _____	Date: _____
Relationship to Patient: _____	

Please have your insurance card available, including Medicare card if applicable.

INSURANCE INFORMATION

Complete this section if receiving a vaccine at an off-site clinic or if you do not have your insurance information with you.

Name as it appears on Insurance/Medicare Card: _____	
Member ID: _____	Rx Group: _____
Rx BIN: _____	Rx PCN: _____
Medicare Beneficiary ID: _____	
SS# (if no other information is available): _____	

FOR INTERNAL USE ONLY

Vaccine Name / Manufacturer	Lot Number	Expiration Date	Dose	Injection Site	VIS / Current VIS Given?	Vaccine Administered By	Supervising Pharmacist	Date Administered
Clinic Site: _____					Access to / Current VIS: ☐ Yes ☐ No			
Supervising Pharmacist (if administered by technician): _____					Additional Notes: _____			

Please complete all applicable sections before receiving your vaccination.