

Insurance Card: _____ ID: _____ Rx Group: _____ I do not have insurance
Medicare#: _____

Screening Questionnaire, Consent and Physician Fax Form

Patient Information: (Patient to complete)

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

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

Gender: M or F

Primary Doctor: _____ Dr. Phone: _____

Dr. Address: _____ Dr. Fax: _____

Which vaccine(s) would you like to receive today? _____

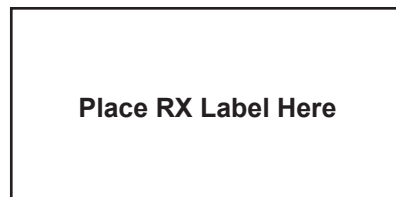
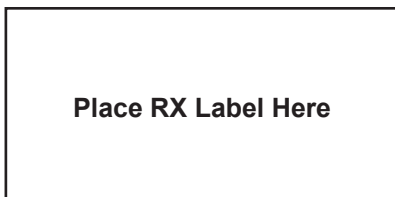
Medical Conditions: _____

Ethnicity: _____

Pharmacy Use Only

Dear Doctor: Today the above patient was vaccinated with the following immunizations at our store, please retain for your records.

<input type="checkbox"/> Influenza Injectable VIS Date: _____	<input type="checkbox"/> Meningococcal VIS Date: _____	<input type="checkbox"/> Zoster (Shingles) VIS Date: _____
<input type="checkbox"/> Pneumococcal VIS Date: _____	<input type="checkbox"/> Td VIS Date: _____	<input type="checkbox"/> Tdap VIS Date: _____
<input type="checkbox"/> Hepatitis B VIS Date: _____	<input type="checkbox"/> Hepatitis A VIS Date: _____	<input type="checkbox"/> Hepatitis A & B VIS Date: _____
<input type="checkbox"/> HPV VIS Date: _____	<input type="checkbox"/> MMR VIS Date: _____	<input type="checkbox"/> Influenza Nasal VIS Date: _____
<input type="checkbox"/> Varicella VIS Date: _____	<input type="checkbox"/> DTap VIS Date: _____	<input type="checkbox"/> Hib VIS Date: _____
<input type="checkbox"/> Covid VIS Date: _____	<input type="checkbox"/> Other VIS Date: _____	<input type="checkbox"/> Other VIS Date: _____



Date VIS was given to patient: _____

Date VIS was given to patient: _____

Lot # _____

Lot # _____

Exp Date: _____

Exp Date: _____

Site LA or RA (Circle one)

Site LA or RA (Circle one)

Signature of pharmacist or intern who administered Vaccine(s): _____

License #: _____ Date: _____

Patient Information: (Patient to complete this section.)

The following questions will help us determine which vaccines may be given today. If a question is not clear, please ask your pharmacist to explain it.

	Yes	No	Don't Know
1. Are you sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have allergies to medications, food (ie eggs), latex or any vaccine (ie neomycin)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had a serious reaction after receiving a vaccination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have cancer, leukemia, AIDS, or any other immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had X-ray treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. During the past year, have you received a transfusion of blood or blood products, including antibodies?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you received any vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have a neurological disorder such as seizures or other disorders that affect the brain or have a neurological disorder that resulted from a vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. For women: Are you pregnant or is there a chance you could become pregnant in the next three months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. I request that the pharmacists DOES NOT send a copy of my vaccine document to my primary care provider (if state regulations allow).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Did you bring your immunization record card with you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- The Pharmacist recommends and encourages our vaccinated patient to remain in the waiting area, post immunization, for 20 minutes.
- If the patient's insurance does not cover the cost of administering the vaccine at the pharmacy, then payment must be made at the time of the administration of the vaccine.
- I have read, or have had read to me the Vaccination Information Sheet (VIS) regarding the vaccine(s). I have had the opportunity to ask questions that were answered to my satisfaction and understand the benefits and risks of the vaccine(s). I consent to, or give consent for, the administration of the vaccine(s). I fully release and discharge Towne Drugs, LLC, its affiliates, their officers, directors, and employees from and liability for illness, injury, loss, or damage which may result there from.

Patient Signature: _____

or Legal Guardian Signature: _____

If Legal Guardian Print Name: _____