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.

☐ Influenza Injectible VIS Date: _____	☐ Meningococcal VIS Date: _____	☐ Zoster (Shingles) VIS Date: _____
☐ Pneumococcal VIS Date: _____	☐ Td VIS Date: _____	☐ Tdap VIS Date: _____
☐ Hepatitis B VIS Date: _____	☐ Hepatitis A VIS Date: _____	☐ Hepatitis A & B VIS Date: _____
☐ HPV VIS Date: _____	☐ MMR VIS Date: _____	☐ Influenza Nasal VIS Date: _____
☐ Varicella VIS Date: _____	☐ DTap VIS Date: _____	☐ Hib VIS Date: _____
☐ Covid VIS Date: _____	☐ Other VIS Date: _____	☐ Other VIS Date: _____

Place RX Label Here

Place RX Label Here

Date VIS vas given to patient:_____ Date VIS vas 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?	☐	☐	☐
2.	Do you have allergies to medications, food (ie eggs), latex or any vaccine (ie neomycin)?	☐	☐	☐
3.	Have you ever had a serious reaction after receiving a vaccination?	☐	☐	☐
4.	Do you have cancer, leukemia, AIDS, or any other immune system problem?	☐	☐	☐
5.	Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had X-ray treatments?	☐	☐	☐
6.	During the past year, have you received a transfusion of blood or blood products, including antibodies?	☐	☐	☐
7.	Have you received any vaccinations in the past 4 weeks?	☐	☐	☐
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?	☐	☐	☐
9.	For women: Are you pregnant or is there a chance you could become pregnant in the next three months?	☐	☐	☐
10.	I request that the pharmacists **DOES NOT** send a copy of my vaccine document to my primary care provider (if state regulations allow).	☐	☐	☐
11.	Did you bring your immunization record card with you?	☐	☐	☐

- 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: _____