PATIENT SCREENING AND CONSENT FORM

PATIENT INFORMATION *(Please print clearly)*

Last Name: **First Name:** **MI:**	**D.O.B:**	**Age:**	**Gender:**
Race Ethnicity **American Indian/Alaska Native** **Black/African American** **Hispanic/Latino** **Native Hawaiian/Other Pacific Islander** **White** **Asian** **Other**			
Home Address:	**Contact Phone:**		
City:	**State:**	**Zip:**	
Primary Care Physician	**Physician Phone**		

SCREENING QUESTIONNAIRE

(The following questions will help us determine your eligibility to be vaccinated today)

ALL VACCINES	Yes	No	Don't Know
Are you feeling sick, or experiencing a moderate to high fever today?			
Do you have any allergies to medications, food (i.e. eggs), latex, vaccine component (e.g. neomycin, formaldehyde, gentamicin, thimerosal, bovine proteins, phenol, polymyxin, gelatin, baker's years or yeast)?			
Have you ever had a serious reaction to any vaccinations, including fainting and feeling dizzy?			
Have you ever had a health problem with lung, heart, kidney, or metabolic disease (e.g. diabetes), asthma, or a blood disorder. If yes, please list:			
Have you ever had a seizure disorder for which the patient is on seizure medication(s), a brain disorder, Guillain–Barré syndrome (a condition that causes paralysis) or other nervous system problem?			
For women: Are you pregnant or considering becoming pregnant in the next month?			

HAS THE PATIENT HAD THE FOLLOWING VACCINES:	Yes	No	Don't Know
Pneumococcal Vaccine			
Shingles Vaccine			
Tdap (Whooping Cough) Vaccine			

I certify that I am (a) the patient and at least 18 years of age or (b) the parent or legal guardian of the patient. Further, I hereby consent to the healthcare provider of Curtis Pharmacy to administer the vaccine(s) I have requested above. I understand the risks and benefits associated with the above vaccine(s) and have received, read and/or had explained to me the Vaccine Information Statements on the vaccine(s) I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. On behalf of myself, my heirs, personal representatives, I hereby release and hold harmless the applicable Provider, its staff, agests, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees form any and all liabilities or claims whether known or unknown arising out of, in connection with, or in anyway related to the administration of the vaccine(s) listed above. I acknowledge that I understand the purposes/benefits of my state's immunization registry ("State Registry") and the Provider may disclose my immunization information to the State Registry. I acknowledge that, depending upon my state's law, I may prevent the disclosure of my immunization information by this applicable Provider to the State Registry by using this opt-out form. The Provider will, if my state permits, provide me with an Opt-out form. I understand that, depending on my state's law, I may need to specifically consent, and to the extent required by my state's law, by signing below, I hereby do consent to the Provider reporting my immunization information to the State Registry. I understand that even if I do not consent or if I withdraw my consent, my state's laws may permit certain disclosures of my immunization information as required or permitted by law. I voluntarily authorize and direct my healthcare provider at Curtis Pharmacy to use or disclose my health information during the term of this Authorization to the physician responsible for this protocol of specific health information of people vaccinated at Curtis Pharmacy, my primary care physician, my insurance, and/or state or federal registries, where required, for the purpose of treatment, payment or other healthcare operations. I further agree to be fully financially responsible for any cost sharing amount, including copays, coinsurance, and deductibles, for the requested items and services as well as for any requested items and services not covered by my insurance benefits. I understand that any payment for which I am financially responsible is due at the time of service.

PATIENT NAME: _____

PATIENT SIGNATURE:_____ DATE: _____

PHARMACY USE ONLY

Vaccine	NDC	Manufacturer	Dose	VIS	Lot #	Exp. Date	Site of Admin	Route of Admin

PHARMACIST SIGNATURE: _____

ADMINISTRATION DATE: _____ DATE VIS GIVEN TO PATIENT: _____