IIS:

IMMUNIZATION CONSENT & SCREENING FORM

Patient Information

First Name: _____MI: ____Last Name: _____

DOB: ___/___/____ Age: ____Gender: _____

Address: _____

City: _____State: ___Zip: _____County: _____

Phone: _____Email: _____

Primary Care Physician: _____Phone: _____City: _____

Ethnicity: ■ Hispanic/Latino ■ Non-Hispanic/Latino ■ Prefer not to answer

Requested Vaccine(s): _____

Screening Questions (Check one box per line)

#	Question	Yes	No	DK
1	Are you sick or running a fever today?			
2	Allergies to meds/food/latex/vaccine components? If yes, list: _____			
3	Blood transfusion or immune globulin in past year?			
4	Serious reaction to vaccines (fainting/dizzy)?			
5	Long-term health issues (heart, lung, kidney, diabetes, asthma, etc.)? List:			
6	Seizure disorder, brain disorder, Guillain-Barré, or nervous system problems?			
7	Pregnant or planning pregnancy in next month?			
8	Cancer, leukemia, HIV/AIDS, or immune problems?			
9	Parent/sibling with immune problem?			
10	Taken immune-suppressing meds or radiation in past 6 months?			
11	Diagnosed with myocarditis, pericarditis, or MIS-A/MIS-C after COVID-19?			
12	Ever received Pneumococcal vaccine?			
13	Ever received Shingles vaccine?			
14	Ever received Tdap (Whooping Cough) vaccine?			

By signing below, I certify that I am: (a) the patient (≥18 yrs) or (b) the parent/legal guardian of the patient. I consent to Colonial Pharmacy administering the above vaccine(s). I understand the risks, benefits, and have reviewed the Vaccine Information Statement(s). I agree to wait 15 minutes post-vaccination. I release Colonial Pharmacy, its staff, and affiliates from liability related to vaccine administration. I authorize reporting of my immunization record to my state registry, unless I complete an opt-out (if permitted). I authorize disclosure of health info for treatment, billing, or registry purposes. I agree to be financially responsible for any uncovered costs, due at service.

Patient First Name: _____Last Name: _____

Patient/Guardian Signature: _____Date: _____

IIS:

Pharmacy Use Only – Vaccine Administration Record

Vaccine	NDC	MFG	Dose	VIS Date	Lot #	Exp Date	Site	Route
Influenza (Injectable)								IM
Influenza (Nasal)								Nasal
Hepatitis A								IM
Hepatitis B								IM
Hepatitis A&B								IM
Zoster (Shingles)								IM
Pneumococcal								IM/SQ
Meningococcal								IM/SQ
TD								IM
Tdap								IM
MMR								SQ
DTaP								IM
Varicella								SQ
HPV								IM
HiB								IM
COVID-19								IM
RSV								IM
Other: _____								IM/SQ

Administered By (Signature): _____

Supervising Pharmacist (if applicable): _____

Date VIS Given to Patient: _____/_____/_____