IIS -

IMMUNIZATION SCREENING AND CONSENT FORM

PATIENT INFO

First Name	MI	Last Name

Email Address	Phone

Address

City	State	Zip	County

Date of Birth	Age	Gender

Ethnicity

- ☐ Hispanic/ Latino
- ☐ Not Hispanic/ Latino
- ☐ Unknown

Race

- ☐ American Indian / Alaska Native
- ☐ Native Hawaiian / Other Pacific Islander
- ☐ Black / African American
- ☐ Caucasian
- ☐ Asian
- ☐ Other
- ☐ Unknown

Primary Care Physician Information

Physician's Full Name	Phone Number	City

Requested Vaccines

(*Which vaccine(s) would the patient like to receive today?*

- ☐ Influenza (injectable)
- ☐ Influenza (Nasal)
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ COVID-19
- ☐ HPV
- ☐ Zoster (Shingles)
- ☐ Pneumococcal
- ☐ Meningococcal
- ☐ Td
- ☐ DTaP
- ☐ Tdap
- ☐ MMR
- ☐ Varicella
- ☐ RSV
- ☐ Other

Screening Questions

All Vaccines

	YES	NO	DON'T KNOW
1. Are you feeling sick or experiencing a moderate to high fever today?	☐	☐	☐
2. Do you have any allergies to medications, food, latex, vaccine component (e.g. neomycin, ormaldehyde, gentamicin, thimerosal, bovine protein, phenol, polymyxin, gelatin, bakers yeast or yeast)? If yes, please list:	☐	☐	☐
3. During the past year, have you received any transfusion of blood or blood products, or been given a medication called immune (gamma) globulin?	☐	☐	☐

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	YES	NO	DON'T KNOW
4. Have you ever had a serious reaction to any vaccinations, including fainting, and feeling dizzy?	☐	☐	☐
5. Do you have any of the following: a long-term health problem with heart, lung, kidney or metabolic disease (e.g diabetes), asthma, a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak? Are you on long term asprin therapy? If yes, please list:	☐	☐	☐
6. Have you ever had a seizure disorder for which you were on seizure medication(s), a brain disorder, Guillain-Barre' Syndrome (a condition that causes paralysis) or other nervous system problems?	☐	☐	☐
7. Are you pregnant or considering becoming pregnant in the next month?	☐	☐	☐
8. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
9. Do you have a parent, brother or sister with an immune system problem?	☐	☐	☐
10. In the past 6 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?	☐	☐	☐
11. Have you ever been diagnosed with a heart condition (myocarditis or pericarditis) or have you had Multisystem Inflammatory Syndrome (MIS-A or MIS-C) after an infection with the virus that causes COVID-19?	☐	☐	☐
Has the patient had any of the following vaccines?			
12. Pneumococcal vaccine	☐	☐	☐
13. Shingles vaccine	☐	☐	☐
14. Tdap (Whooping Cough) vaccine	☐	☐	☐

By signing below, 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 give my consent to the healthcare provider of **Colonial 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. Additionally, it is recommended to wait for 15 minutes following the vaccination before leaving the premises. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless the applicable Provider, its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way 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 the applicable Provider to the State Registry by using the 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 **Colonial 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 **Colonial 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 amounts, 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 First Name	**Patient Last Name**

Patient Signature (Parent or Guardian, if Minor)	**Date**

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FOR PHARMACY USE ONLY

Vaccine	NDC	MFG	Dose	VIS Date	Lot #	Exp Date	Site of Admin	Route of Admin	
☐ Influenza (Injectable)								☐ IM	
☐ Influenza (Nasal)								☐ Nasal	
☐ Hapatitis A								☐ IM	
☐ Hepatitis B								☐ IM	
☐ Heptitis 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 Signature (if applicable)

Date VIS Given to Patient