Lake Murray Drug Company Vaccine Screening and Consent Form

Requested Vaccine: Flu / Covid (12+) / Pneumonia / RSV / Shingles / Tetanus-Whooping Cough / Hepatitis A or B / Other:_____

PATIENT INFORMATION				
Name:	**Date of Birth:**	**Age:**	**Phone #:**	
Address:	**City:**		**State:**	**Zip Code:**
Primary Care Provider (LMDC notifies this provider)	**Primary Care Provider location: (Practice City, State)**			
Gender: M or F	**Race:** Asian / Black or African American / White / American Indian or Alaskan Native / Native Hawaiian or Pacific Islander			
Mother's Maiden Name: (For Immunization Registry)	**Ethnicity:** Hispanic or Latino / Not Hispanic or Latino / Unknown	**Weight:** Below 77 pounds / Above 77 pounds	**Weight for ages 3 to 11:** _____lbs	

SCREENING QUESTIONS FOR ALL VACCINES			
Are you sick today? If yes, circle symptoms: new fever, cough, diarrhea, vomiting	Yes	No	Unsure
Have you ever fainted or felt dizzy after receiving a vaccine?	Yes	No	Unsure
Have you ever had a reaction after receiving a vaccine?	Yes	No	Unsure
Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g., diabetes), or anemia or another blood disorder?	Yes	No	Unsure
Do you have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long-term treatment with drugs such as high-dose steroids, or cancer treatment with radiation or drugs?	Yes	No	Unsure
Do you have allergies to latex, medications, food, or vaccines? (Examples: eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast, or thimerosal)	Yes	No	Unsure
Have you ever had a seizure disorder for which you are on seizure medications, a brain disorder, Guillain-Barre Syndrome or other nervous system problems?	Yes	No	Unsure
Are you a parent, family member, or caregiver to a newborn infant?	Yes	No	Unsure
Do you consider yourself to be, or have you ever been told by a physician that you are immunosuppressed?	Yes	No	Unsure
Are you currently on home infusions or weekly injections (such as Remicade, Humira, Enbrel, Cimzia, Simponi Aria, Xeljanz, Orencia, Arava, Actemra, Cytoxan, Rituxan, adalimumab, infliximab or etanercept), high-dose methotrexate, azathioprine or 6-mercaptopurine, antivirals, anti-cancer drugs or radiation treatments?	Yes	No	Unsure
Have you received any vaccinations or skin test in the past 4 weeks?	Yes	No	Unsure
Have you received a transfusion of blood, blood products or been given a medication called immune (gamma) globulin in the past year?	Yes	No	Unsure
Are you currently taking high-dose steroid therapy (prednisone >20mg/day or equivalent) for longer than two weeks?	Yes	No	Unsure
FOR WOMEN: Are you pregnant or considering becoming pregnant in the next month?	Yes	No	Unsure
Which arm would you like to receive vaccine in today?	Left	Right	
COVID VACCINE ONLY:			
Have you ever had an allergic reaction to a component of Covid-19 vaccine, including: • Polyethylene glycol (PEG)- found in some meds, such as laxatives & colonoscopy preps) • Polysorbate- found in some vaccines, film coated tablets, & intravenous steroids	Yes	No	Unsure
Circle all that may apply: • History of myocarditis or pericarditis • Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a Covid-19 infections • Have a history of Heparin-induced thrombocytopenia (HIT)	Yes	No	Unsure

- Lake Murray Drug Co. is providing necessary vaccines to you in a safe and convenient setting to promote adherence to current immunization guidelines recommended by the CDC and ACIP. It does not take the place of an ongoing relationship with your primary care provider to address ongoing medical issues and other types of preventive care. We are providing your primary care provider with records of the vaccine(s) administered here so that your medical records may be complete but be sure to take your personal record with you to your next appointment.
- Please review the statement below confirming your consent for vaccination and provide the information requested.
- I have read or had explained to me, the Vaccination Information Statement (VIS) regarding the vaccine(s). I understand the risks and benefits and have had sufficient time to thoughtfully consider whether to accept/decline this vaccine. I have been provided an opportunity to ask questions, which have been answered to my satisfaction. I wish to receive the vaccine(s) and I am in no way being unduly influenced, coerced, or otherwise forced to receive this vaccine, and hereby give consent for the pharmacist or pharmacy intern/pharmacy technician with supervising pharmacist to administer the vaccine(s) and communicate the administration of the vaccine to my primary care practitioner listed above. I fully release and discharge Lake Murray Drug Co., officers, and employees from any liability for illness, injury, loss, or damage which may result there from.
- I authorize the release of any medical or other information with respect to this vaccine(s) to my healthcare providers, Medicare, Medicaid or other third-party agents as needed and request payment of authorized benefits to be made on my behalf to Lake Murray Drug Co.
- I acknowledge that if my 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 acknowledge that my vaccination record will be shared with federal or state or city agencies for registry reporting.
- I acknowledge that the pharmacist recommends that the vaccinated patient should remain in the waiting area for 15 minutes after the administration of the immunization.
- I acknowledge receipt of Lake Murray Drug Co. notice of privacy practices for protected health information.

Patient Signature or legal guardian_____**Date:**_____

If legal guardian print name here:_____

FOR PHARMACY USE ONLY

Date of Vaccination(s):

Administered at: Lake Murray Drug Co
105 Snapdragon Court Suite A
803-345-9999

Lake Murray Drug Co Irmo
2 Palmetto Wood Parkway Suite 100
803-212-9999

Administered by: Justin Carter - 12207 Wendy Grooms - 7228 Billy Mai – 43080 Mirena Kovacheva - 13762
Ashley Smith – 8587 Whitney Rodgers - 35748 Other:_____
Signature:_____ RPh / Intern

	Vaccine	Lot / Expiration	Dose	Manufacturer	VIS Date	Admin Site	Route
	Abrysvo		0.5 mL	Pfizer	10/17/2024	Right arm / Left arm	IM
	Shingrix 1st / 2nd		0.5 mL	GSK	02/04/2022	Right arm / Left arm	IM
	Flucelvax		0.5mL	Seqirus	08/06/2021	Right arm / Left arm	IM
	Fluad		0.5 mL	Seqirus	08/06/2021	Right arm / Left arm	IM
	Comirnaty		0.3 mL	Pfizer	10/17/2024	Right arm / Left arm	IM
	Spikevax		0.5 mL	Moderna	10/17/2024	Right arm / Left arm	IM
	Prevnar 20		0.5 mL	Wyeth	05/12/2023	Right arm / Left arm	IM
	Boostrix		0.5 mL	GSK	08/06/2021	Right arm / Left arm	IM
	Havrix		1 ml	GSK	10/15/2021	Right arm / Left arm	IM
	Engerix - B		1 ml	GSK	05/12/2023	Right arm / Left arm	IM
						Right arm / Left arm	IM / SC

PHARMACY LABEL HERE

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