LAKE MURRAY DRUG CO.

# SC Immunization Screening Questionnaire and Consent Form

**Patient Information: (Patient to complete)**

Patient Name:_____Date of Birth:_____Age_____Phone#_____

Address:_____City:_____State:_____Zip:_____

Gender: M or F Which Vaccine(s) would you like to receive today?_____

Medical Conditions:_____Weight if less than 110 lbs:_____

Primary Care Provider:_____Provider City, State_____

Required for SC Immunization Registry: Mother's maiden name_____ Race_____

ALL Vaccines

| Screening Questions for All Vaccines | Yes | No | Don't Know |
|---|---|---|---|
| Are you 12 years of age or older? | | | |
| Are you sick today? | | | |
| If yes to the above question: Do you have a new fever? | | | |
| Do you have a cough? | | | |
| Do you have diarrhea? | | | |
| Have you been vomiting? | | | |
| Have you ever fainted or felt dizzy after receiving a vaccine? | | | |
| Have you ever had a reaction after receiving a vaccine? | | | |
| 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? | | | |
| 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? | | | |
| Do you have allergies to latex, medications, food or vaccines? (Examples: eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal) | | | |
| 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? | | | |
| Are you a parent, family member, or caregiver to a newborn infant? | | | |
| *For women*: Are you pregnant or considering becoming pregnant in the next month? | | | |
| Did you bring your Immunization Record Card with you? | | | |

LIVE Vaccines Only

| Screening Questions in addition to the above for LIVE Vaccines | Yes | No | Don't Know |
|---|---|---|---|
| Do you consider yourself to be, or have you ever been told by a physician that you are immunosuppressed? | | | |
| Are you currently on home infusions or weekly injections (such as Remicade, Humira, Enbrel, Cimzia, Simponi, 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? | | | |
| Have you received any vaccinations or skin tests in the past 4 weeks? | | | |
| Have you received a transfusion of blood, blood products or been given a medication called immune (gamma) globulin in the past year? | | | |
| Are you currently taking high-dose steroid therapy (prednisone >20mg/day or equivalent) for longer than two weeks? | | | |

**OVER** → → → → → → → → → → → → → → → → → → → → → →

Lake Murray Drug Co. is providing necessary vaccines to you in a safe and convenient setting in order 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 have had read or explained to me, the Vaccination Information Statement (VIS) regarding the vaccine(s). I understand the risks and benefits, and have been provided an opportunity to ask questions, which have been answered to my satisfaction. I wish to receive the vaccine(s) and hereby give consent for the pharmacist or pharmacy intern 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**:_____

<table>
<tr><th colspan="5">FOR PHARMACY USE ONLY</th></tr>
<tr><td colspan="5">Type of Vaccine: ☐ Influenza ☐ Pneumococcal ☐ Tdap ☐ Other_____</td></tr>
<tr><td colspan="3">Date of Vaccination(s):</td><td colspan="2">☐ Male ☐ Female</td></tr>
<tr><td>Vaccine #1 Name and Dose:</td><td>Mfr:</td><td>Lot Number:</td><td>Expiration:</td><td>IM / SQ<br>Left / Right</td></tr>
<tr><td>Vaccine #2 Name and Dose:</td><td>Mfr:</td><td>Lot Number:</td><td>Expiration:</td><td>IM / SQ<br>Left / Right</td></tr>
<tr><td colspan="3">RPH Name and License #</td><td colspan="2">RPH Signature:</td></tr>
<tr><td colspan="2">VIS Date(s): VAX #1 VAX #2</td><td colspan="3">Adverse Reaction (if applicable):</td></tr>
<tr><td colspan="2">Space for Pharmacy Use<br>Place Pharmacy Label Here</td><td colspan="3">Space for Pharmacy Use<br>Place Pharmacy Label Here</td></tr>
</table>