Screening Questionnaire for Immunization and Consent

Patient Name: _____ Date of Birth: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Gender: M or F Weight: _____ Drug Allergies: _____

The following questions will help us determine which vaccines may be given today. If a question is not clear, please ask your pharmacist/nurse to explain it.

		Yes	No	Don't Know
1.	Are you sick today?	□	□	□
2.	Do you have allergies to medications, food (ie. eggs) or any vaccine?	□	□	□
3.	Have you ever had a serious reaction after receiving a vaccination?	□	□	□
4.	Do you have cancer, leukemia, AIDS, or any other immune system problem?	□	□	□
5.	For women: Are you pregnant or is there a chance you could become pregnant in the next month?	□	□	□
6.	Have you received any vaccinations in the past four weeks?	□	□	□

It is important for you to have a personal record of your vaccinations. If you don't have a record card, ask your pharmacist/nurse to give you one. Bring this record with you every time you seek medical care.

Which vaccine would you like to receive today?

Seasonal Influenza

I have read, or have had read to me the Vaccination Information Sheet (VIS) regarding the vaccine(s) marked above. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s). I consent to, or give consent for, the administration of the vaccine(s) marked above and the notification of my primary care physician. I fully release and discharge Hoagland Pharmacy, its affiliates, directors and employees from any liability for illness, injury, loss, or damage which may result there from.

MEDICARE RECIPIENTS PLEASE COMPLETE THIS SECTION BELOW:

Please check one:

□ I hereby authorize the pharmacy to bill Medicare Part B on my behalf. I request that payment of authorized Medicare benefits be made to the pharmacy for **the marked vaccine(s)** and administration as furnished to me by the pharmacy. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits payable for related services.

□ I hereby attest that as of the date indicated above, I am **not** enrolled in Medicare Part B.

Patient Name (print): _____ Patient/Legal Guardian Signature: _____

If not the patient, this form was completed by: _____ Relation to Patient: _____

Manufacturer: _____	Manufacturer: _____	Manufacturer: _____	Manufacturer: _____
Lot #: _____	Lot #: _____	Lot #: _____	Lot #: _____
Exp Date: _____	Exp Date: _____	Exp Date: _____	Exp Date: _____
Site of Vaccination: _____	Site of Vaccination: _____	Site of Vaccination: _____	Site of Vaccination: _____
VIS Date: _____	VIS Date: _____	VIS Date: _____	VIS Date: _____

Signature of Person who Administered Vaccine(s): _____ Date: _____

Insurance: _____ BIN: _____ PCN: _____ ID#: _____ GRP: _____