Vashon Pharmacy Immunization Screening Checklist

Patient Information: (Patient to complete)*

***Patient Name: ____*Date of Birth: _________ ___*Age: ______**

***Phone# __________________**

***Address: ________________________________*City: __________________*State: _____ __*Zip:_____________**

***Gender: M or F - RACE: ______________ Ethnicity:** Hispanic or Latino – Not Hispanic or Latino

***Medical Conditions: ______________________________ *Primary Doctor: ________________________**

Which vaccine(s) would you like to receive today? (check all that apply)

- ☐ **Standard Flu (Flu) IM Shot (ages 4 and up)**
- ☐ **HD/AD Flu (IM – Ages 65 & Up)**
- ☐ **SHINGRIX(Shingles – Ages 50 & up) Dose 1 or 2**
- ☐ **Prevnar 13 (Newer Pneumonia Vaccine – Ages 65 & up)**
- ☐ **Pneumovax 23 (Pneumonia Vaccine – Ages 65 & up)**
- ☐ **TdaP (Tetanus, Diph, Pertussis (Ages 10-12* & 18-64))**

Other (may include MMR, Hepatitis A, Hepatitis B, Hep A+B, Polio, Varicella or other): ___________________________________

FOR Patients, Parents/Guardians: The following questions will help us determine which vaccines you or your child may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. <u>If a question is not clear, please ask the pharmacist to explain it.</u>

	Question	YES	NO	Don't know
1.	Are you sick today?	☐	☐	☐
2.	Do you have allergies to medications, food, a vaccine component, or latex?	☐	☐	☐
	a. If yes please list here___________________________________			
3.	Have you ever had a serious reaction after receiving a vaccine?	☐	☐	☐
4.	Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (eg diabetes), anemia, or other blood disorder?	☐	☐	☐
5.	Do you have cancer, leukemia, AIDS, or any other immune system problem?	☐	☐	☐
6.	Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?	☐	☐	☐
7.	Have you had a seizure or a brain or other nervous system problem?	☐	☐	☐
8.	During the past year, have you received a blood transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
9.	FOR WOMEN: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
10.	Have you received any vaccinations in the past 4 weeks?	☐	☐	☐

- I authorize the pharmacist to send copies of my vaccine documents to my primary care provider. (Circle one) **YES** or **NO**
  -Failure to circle one of the above will result in the vaccine documents being sent to my primary care provider, if known, as state laws & regulations require for my state.

- SEE REVERSE SIDE FOR ADDITIONAL INFORMATION AND REQUIRED SIGNATURE

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- I authorize the release of any medical or other information with respect to this vaccine to my healthcare providers, Medicare, Medicaid or other third party payer as needed and request payment of authorized benefits to be made on my behalf to Vashon Pharmacy.
- 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 may be shared with federal or state or city agencies for registry reporting.
- I acknowledge that the pharmacist recommends that vaccinated patients should remain in the waiting area, for 20 minutes, after the administration of the immunization.
- I acknowledge receipt of Vashon Pharmacy's Notice of Privacy Practices for Protected Health Information.
- I acknowledge that the administration of an immunization or vaccine does not substitute for an annual check-up with the patient's primary care physician.
- I have read, or have had read to me the Vaccination Information Sheet (VIS) regarding the vaccine(s). I have had the opportunity to ask questions that were answered to my satisfaction and understand the benefits and risks of the vaccine(s). I consent to, or give consent for, the administration of the vaccine(s). I fully release and discharge Vashon Pharmacy, its affiliates, officers, directors, and employees from any liability for illness, injury, loss, or damage which may result there from.

Patient Signature:_________________ ____________________ ***Date***______________________

Please Print Guardian Name:___________________________

(If under the age of 18: Parent/legal guardian signature):

DO NOT WRITE BELOW HERE – THE BELOW SECTION IS FOR PHARMACIST USE ONLY

Steve Bird – PH00015190 - **Tyler Young** – PH60369774 – **Chris Davila** – PH60870886

Lauren Allyn – PH60218961 – **Molly Dammeier** – PH60349737 **Evan Mayo** – PH00011729

Admin Location: ☐-Deltoid ☐-Subcutaneous ☐-Nares – ☐-Right ☐-LeftVaccine(s)

Administered: ☐-IM Flu ☐-Nasal Flu ☐-SHINGLES ☐-Prevnar13 ☐-Tdap ☐-Other:_________________

Affix Pharmacy Label Here

Affix Pharmacy Label Here

LOT:_______________________

EXP:_______________________

LOT:_______________________

EXP:_______________________

*Did the patient experience any reactions after the administration of the above vaccinations? **YES or NO***

If Yes, please complete pharmacy immunization incident form along with description of the incident.

Pharmacist Signature:_______________________________ Date:___________________