IMMUNIZATION SCREENING AND CONSENT FORM

Patient Name: _____ **Date of Birth:** _____ **Age:** ____ **Gender:** ____

Street Address: _____

City: _____ **State:** ____ **ZIP:** _____ **Phone:** _____

SSN (*for insurance lookup purposes***):** _____ **Medicare Part B #:** _____

Race		**Ethnicity**
☐ American Indian/Alaska Native	☐ White	☐ Hispanic or Latino
☐ Asian	☐ Other	☐ Not Hispanic or Latino
☐ Native Hawaiian/other Pacific Islander		
☐ Black/African American	☐ Prefer not to say	☐ Prefer not to say

Please select which vaccine(s) you would like to receive today:

☐ Influenza (Flu)	☐ RSV	☐ COVID-19:	☐ Moderna	☐ Pfizer
☐ Hepatitis-B	☐ Shingles			
☐ HPV	☐ Tdap			
☐ Pneumonia		☐ Other: _____		

Primary Care Physician (PCP): _____ ☐ No PCP

I authorize the pharmacy to notify my PCP about the vaccine(s) I have received: ☐ Yes ☐ No

Please answer the following questions. If a question is unclear, please ask a pharmacy member to explain it to you.

	Yes	**No**	**Not Sure**
Are you sick today?			
Do you have any allergies to medications, foods, or vaccine components? *If yes, please list:* _____			
Have you ever had a serious reaction after receiving a vaccine?			
Do you have any major health issues (asthma, diabetes, heart condition, blood disorder, etc.)? *If yes, please list:* _____			
Have you ever had a seizure for which you are on seizure medication, a brain disorder, or other nervous system condition?			
Do you have cancer, leukemia, HIV/AIDS, or any other condition that weakens the immune system?			
Do you take cortisone, prednisone, other steroids, anticancer drugs, or have you had any radiation treatment?			
Within the past year, have you received a blood transfusion?			
Have you received any vaccines within the past four (4) weeks?			
For women only: Are you currently pregnant?			

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 WEDGEWOOD 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 statement 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. On behalf of myself, my heirs, and personal representatives, I hereby release and hold harmless the applicable provide, its staff, agents, successors, divisions, affiliate, 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 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 to the extent required by my state's law, by signing below I hereby do consent to the provider reporting my immunization information as required or permitted by law. I voluntarily authorize and direct my healthcare provider at WEDGEWOOD PHARMACY to use or disclose my health information during the term of the Authorization to the physician responsible for this protocol of specific health information of people vaccinated at WEDGEWOOD 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 / Guardian Signature: _____ **Date:** _____

WEDGEWOOD PHARMACY

PHARMACY USE ONLY

Affix Pharmacy Label Here

Lot: _____

Exp: _____

Admin. Site: ☐ Left Arm ☐ Right Arm

Affix Pharmacy Label Here

Lot: _____

Exp: _____

Admin. Site: ☐ Left Arm ☐ Right Arm

Affix Pharmacy Label Here

Lot: _____

Exp: _____

Admin. Site: ☐ Left Arm ☐ Right Arm

Administering Pharmacist Signature: _____ **Date:** _____