Requested Vaccine: Flu / Pneumonia / Shingles / RSV / Tetanus / Hepatitis B / Other:_____
COVID: Moderna (12+) / Pfizer (12+)

Vaccine Screening and Consent Form

PATIENT INFORMATION			
First Name:	**Last Name:**	**DOB:**	**Age:**
Address:	**City:**	**State:**	**Zip Code:**
Insurance: Private / Medicare Part B / None **Medicare #** (Red/White/Blue Card):		**SSN:** **Phone #:**	

Please Circle:

Gender: Female / Male / Other
Race: Asian / Black or African-American / White / American Indian or Alaskan Native / Native Hawaiian or Pacific Islander
Ethnicity: Hispanic or Latino / Not Hispanic or Latino / Unknown

********Please answer the following questions********	Yes	No	Unsure
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 (diabetes), or anemia or other 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? Ex. Eggs, bovine protein, gelatin, gentamicin, 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
COVID ONLY: 1. Have you ever had an allergic reaction to a component of COVID-19 vaccine, including: o Polyethylene glycol (PEG) – found in some meds, such as laxatives & colonoscopy preps o Polysorbate – found in some vaccines, film coated tablets, & intravenous steroids 2. **Check all that may apply to you** ☐ History of myocarditis or pericarditis ☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection ☐ Have a history of heparin-induced thrombocytopenia (HIT)	Yes	No	Unsure
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	Either

**I have read, or had explained to me, the Vaccine Information Statement for the indicated vaccine. I understand the risks and benefits, and have been provided an opportunity to ask questions, and they have been answered to my satisfaction. I wish to receive this vaccination and hereby give consent for a Prosperity Drug Co. pharmacist or supervised intern to administer the vaccine and communicate the administration of the vaccine to my primary care physician listed above.*

Signature of Patient: _____ Date: _____

Date Vaccine Administered (VIS date given to patient)

_____Shingrix(02/04/22)●GSK●0.5ml●IM Left/Right●(1st / 2nd) _____Abrysvo (10/19/23)●Pfizer●0.5ml●IM Left/Right _____Prevnar20(02/04/22)●Wyeth●0.5ml●IM Left/Right _____Boostrix(08/06/21)●GSK●0.5ml●IM Left/Right _____ Other_____(/ /)●_____●____ ml●IM/SQ Left/Right	_____**65+FluzoneHi**(08/06/21)●Sanofi●0.5 ml●IM Left/Right _____Afluria(08/06/21)●Seqirus●0.5 ml●IM Left/Right _____Fluzone(08/06/21)●GSK●0.5 ml●IM Left/Right _____Fluarix(08/06/21)●GSK●0.5 ml●IM Left/Right
_____Comirnaty(10/19/23)●Pfizer●0.3 ml●IM Left/Right _____Spikevax(10/19/23)●Moderna●0.5 ml●IM Left/Right	**Lot/Expiration (sticker)**

Administered by:

RPh: D. Crawford (42645) / M. Montgomery (12640) / L. Kyzer (11418) / C. Monts (11465) / A. Crayne (43982)

Other: _____

Interns/Students: M. Gutierrez (50448) / Other: _____

Signature:_____ **Date:** _____