Patient information

Patient name (as it appears on your insurance card)

DOB (MM/DD/YY)

Home Address

Immunization(s) Needed

☑	**Vaccine**	☑	**Vaccine**
	Hepatitis A Vaccine, IM		Hepatitis B Vaccine, IM
	Human papillomavirus (HPV) Vaccine, IM		Measles, mumps, rubella (MMR) Vaccine, SC
	Meningococcal conjugate (MCV-4) Vaccine, IM		Meningococcal group B (MenB) Vaccine, IM
	Pneumococcal polysaccharide (PPSV-23) Vaccine, IM or SC		Pneumococcal conjugate (PCV13) Vaccine, IM
	Tetanis, diptheria, pertussis (Td/Tdap) Vaccine, IM		Varicella (chicken pox) Vaccine, SC
	Varicella zoster (shingles) Vaccine, IM		Travel vaccinations per non-protocol physician

Immunization screening questionnaire

1. Have you had any allergic or adverse reaction to any vaccination? Yes No

If Yes, please list:

2. Are you currently taking any medications? Yes No

If Yes, please list:

3. Have you ever had an allergic reaction to any medication(s) or to any food? Yes No

If Yes, please list:

4. Do you have an allergy to latex? Yes No

5. Have you ever had any other allergies or allergic reactions, in addition to those described above? Yes No

If Yes, please list:

6. Have you been sick or had a fever of 101 degrees F or higher in the past 48 hours? Yes No

7. Have you had a seizure or other neurological problems, or Guillain-Barre syndrome? Yes No

8. Do you have (or is there a risk that you have) cancer, leukemia, HIV, AIDS or any other immune system problem? Yes No

9. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments? Yes No

10. During the past 12 months, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? Yes No

11. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder? Yes No

12. Have you received any vaccinations in the past 4 weeks? Yes No

If Yes, please list:

13. For women: Are you pregnant or is there a chance that you could become pregnant during the next 30 days? Yes No

14. For women: When was the first day of your last menstrual period? Date: N/A

Patient Consent and Signature

I give consent to Prosperity Health Pharmacy and its staff to vaccinate me with this vaccine. I fully understand that I will be ultimately responsible for any charges if I am not a covered person under the insurance plan, the services are not covered services, or any co-pays, deductibles or coinsurance obligations apply. I have read or have had explained to me the information in the Vaccine Information Statement (VIS) about the vaccine, and I have had the chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request.

Signature

Print Name

Relationship to Patient

Date of Service

To be filled out by the Pharmacy only

Vaccine	Site	Location	Lot #	EXP DATE
1.	**R/L**			
2.	**R/L**			
3.	**R/L**			
4.	**R/L**			

Admin signature and date: