The Medicine Shoppe Boyertown
2 E. Philadelphia Ave, Boyertown, PA 19512
Phone: 610-369-3888

2022-2023 Consent Form and Screening Questionnaire for Immunization

Section I. Personal Information (Please print neatly.)

Patient's Full Name (First, MI, Last): _____ Date of Birth: _____

Age: _____ Gender: ___M ___F List Medical Conditions: _____

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

Phone Number and Email Address: _____ Emergency Contact: _____

Emergency Contact Person's Relationship and Number: _____

Primary Care Doctor: _____ Doctor's Number: _____

Doctor's Address: _____

Please indicate which Vaccine you would like to receive today:_____

Section II. Questionnaire for Immunization

		Please answer these questions by checking the boxes. If the question is not clear, please ask the pharmacist.	Yes	No	Don't Know
ALL	1.	Do you feel sick today?			
	2.	Do you have an allergy to medications, foods or any vaccines? For Example: Eggs, Gelatin, Thimerosal, Neomycin, Gentamicin, or Latex			
	3.	Have you ever had a reaction or fainted after receiving any vaccination?			
	4.	If you are over the age of 65: Have you ever had a Pneumococcal vaccination?			
	5.	If you are over the age of 50: Have you ever had a Shingles vaccination?			
	6.	For women: Are you pregnant or are you planning on becoming pregnant?			
Tdap	7.	Have you ever had a seizure disorder, brain disorder, or Guillain-Barre Syndrome?			
LIVE	8.	Have you received any immunizations in the past 4 weeks? If yes, please specify:			
	9.	Do you have cancer, leukemia, HIV, or any long term health condition (i.e. diabetes, asthma, other)? If yes, please specify:			
	10.	Do you take cortisone, prednisone, other steroids, or anticancer drugs, or, have you had X-ray treatments recently?			
	11.	During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin?			
COVID	12.	Have you received COVID-19 monoclonal antibodies or convalescent plasma in the last 90 days?			
	13.	In the past 2 weeks, have you tested positive for COVID-19 or are you currently being monitored for COVID-19?			
	14.	In the past 2 weeks, have you had a known exposure to someone who tested positive for COVID-19?			
	15.	Have you had a new onset of fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, vomiting, or diarrhea?			

Section III. Influenza Information. For more vaccine info, refer to the appropriate VIS (i.e. Influenza, Pneumococcal, Shingles)

Inactivated Influenza Vaccine (injection) ages 6-months old and older: Created from a dead virus, the flu vaccine will not give you the flu. Injection is in the muscle. Some vaccines contain a preservative called thimerosal; thimerosal-free vaccines are available upon request. Side effects include soreness, redness, or swelling at the injection site. Fever, hoarseness, red or itchy eyes, fatigue, and muscle aches are also possible. These symptoms usually begin soon after the shot and last for one to two days. "High-dose" inactivated influenza vaccine available for people 65 years of age and older.

Live, Attenuated Influenza Vaccine (nasal spray) ages 2-49: Live but attenuated (weakened) virus that is sprayed into the nostrils. Side effects in children (ages 2-17 years of age) include runny nose, nasal congestion, cough, fever, wheezing, headache, muscle ache, and abdominal pain/occasional vomiting/diarrhea. Side effects are generally mild in adults and occur at low frequency. Side effects in adults (18-49 years of age) include runny nose/nasal congestion, cough, chills, tiredness/weakness, sore throat, and headache. These symptoms usually last up to a few days following administration of the vaccine.

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Medicare Part B Number: _____
Insurance Number: _____

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Caring beyond prescriptions.℠

Section IV. Signatures

I understand the benefits and risks of the vaccination(s) as described in the Vaccine Information Statement (VIS), a copy of which was provided with this Consent and Release. I request the vaccine(s) be given to me or to the person named below, a minor for whom I represent that I am authorized to sign this Consent and Release.

Signature of Person to Receive Vaccine (or Parent/Guardian, if Recipient is a Minor): _____

Print Guardian name and number (if Recipient is a Minor): _____ Date: _____

I have received a copy of the notice of Privacy Practices and appropriate CDC Vaccine Information Statement (VIS). I understand the notice of Privacy Practices provides an explanation of the ways in which my health information may be used or disclosed by the Pharmacy and of my rights with respect to my health information. I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.

Signature of Acknowledgment of Notice of Privacy Practices and VIS: _____ Date: _____

IF receiving a COVID-19 Vaccine: I understand the benefits and risks of the COVID-19 vaccine as described in the Emergency Use Authorization (EUA), a copy of which was made available to me with this consent form. I have had a chance 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) and the notification to my primary care provider. I fully release the Medicine Shoppe for any liabilities of illness, injury, loss or damage that may result there from. I understand I should remain in the pharmacy area for 15 minutes for observation in case there is an adverse reaction.

Signature of Acknowledgement of COVID-19 Vaccine Practices: _____ Date: _____

_____(Pharmacy Use Only)_____

Vaccine	Date Administered	Vaccine Lot#	Expiration Date	MFR	Dosage	Injection Site	VIS Date	Amt Paid	Dose #*
Influenza Vaccine Quad (≥6 months)					0.5mL		8/6/21		
Prevnar13					0.5mL		2/4/22		
Prevnar20					0.5mL		2/4/22		
Pneumovax23					0.5mL		10/30/19		
Zoster (Shingles) Shingrix					0.5mL		2/4/22		
High-Dose- Fluad Quad					0.5mL		8/6/21		
Influenza Vaccine Quad-Afluria 9yr and older					0.5mL		8/6/21		
Hepatitis B					0.5mL		10/15/21		
Hepatitis A/B					1 mL		10/15/21		
Tdap (Adacel)					0.5mL		8/6/21		
Tdap (Boostrix)**					0.5mL		8/6/21		
Meningitis					0.5mL		8/6/21		
Yellow Fever					0.5mL		4/1/20		
Typhoid					0.5mL		10/30/19		
COVID-19 Pfizer							EUA approved		
COVID-19 Moderna							EUA approved		
COVID-19 Jannsen							EUA approved		
Other (write):									

*for dose #: please include if it is dose 1, 2, 3, or a booster for the listed vaccine.
**Tdap boostrix is for pregnant women

Signature of Pharmacist who administered vaccine(s): _____ Date _____