☐ Medicare # ________________________
☐ Cash ☐ Other Ins ________________

Screening Questionnaire for Immunization and Consent

Rx meijer pharmacy

Patient Name: ________________________ Date of Birth: __________ Age: _____ Phone#: ______________

Address: ________________________ City: ________________________ State: ____ Zip: __________

Gender: ___ Medical Conditions: ______________ Primary Doctor: ________________ Dr. Phone #: ____________

I acknowledge that I understand the benefits and risks of the requested vaccination as described in the Vaccine Information Sheet, a copy of which is attached to this Consent and Release. I confirm that Meijer Inc., on behalf of its pharmacy operations has answered to my satisfaction all of my questions about the vaccine and the vaccination procedure. I request and consent that the vaccination be given, as I direct Meijer, either to me or to the person named above, a minor for whom I represent that I am authorized to sign this Consent and Release. I understand that I am giving Meijer permission to release any medical or other information necessary to my physician, Medicare, Medicare HMO, or insurance company, as applicable, to enable Meijer to process my insurance claims with respect to the vaccination.

In the event that my insurance does not cover all or part of the vaccine or /administration fee, I will be responsible for payment. Payment is due at time of service.

I, for myself (and for the recipient of the vaccination, if the recipient is a minor), my heirs, executors and assigns hereby release Meijer and its divisions and affiliates and their respective officers, directors, employees, agents and representatives from any and all claims arising out of or in connection with the quality of the below-described vaccine as provided by the manufacturer and any liability for illness, injury, loss or damage which may result there from. I understand that the laws of my state may affect my remedies in connection with this vaccination.

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

Guardian name, if Recipient is a Minor, and Phone Number: ________________________ **Date:** ______________

		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.**	Are you **sick today**?	❐	❐	❐
	2.	Do you have an **allergy** to medications, food or any **vaccines**? Examples: Eggs, Gelatin, Thimerosal, Neomycin, Gentamicin	❐	❐	❐
	3.	Have you ever had a **reaction or fainted after receiving any vaccination**?	❐	❐	❐
	4.	Do you have sensitivity to **latex**?	❐	❐	❐
	5.	**If you are over the age of 65:** Have you ever had a pneumococcal vaccination?	❐	❐	❐
	6.	**If you are over the age of 50:** Have you ever had a shingles vaccination?	❐	❐	❐
	7.	**For women**: Are you pregnant or are you considering becoming pregnant?	❐	❐	❐
Tdap	**8.**	Do you have a seizure disorder or a brain disorder? (For pertussis-containing vaccines)	❐	❐	❐
Live	**9.**	Have you received any vaccinations in the past 4 weeks?	❐	❐	❐
	10.	Do you have **cancer, leukemia, HIV**, or any long term health problems like **diabetes or asthma**?	❐	❐	❐
	11.	Do you take cortisone, prednisone, other steroids, or anticancer drugs, or, have you had X-ray treatments	❐	❐	❐
	12.	During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin?	❐	❐	❐

------------------------BELOW LINE FOR PHARMACY USE ONLY------------------------

Vaccine	Lot# of Vaccine	Exp Date	Manufacturer	Dosage	Site of Injection	VIS Date
Seasonal Influenza				0.5mL	IM L / R Deltoid	
High-Dose influenza			Sanofi	0.5mL	IM L / R Deltoid	
LIVE Influenza			Medimmune	0.2 mL	Intranasal	
Pneumococcal-PPSV23			Merck	0.5mL	IM L / R Deltoid	
Pneumococcal-PCV13			Pfizer/Wyeth	0.5mL	IM L / R Deltoid	
Zoster (Shingles)			Merck	0.65mL	SQ L / R Arm	
Hepatitis B (adult)				1.0.mL	IM L / R Deltoid	

Signature of Pharmacist who administered vaccine(s): ______________________________ **Date:** ______________