Springfield Pharmacy

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North Carolina Screening Questionnaire and Consent Form

Insurance Card:_____ ID:_____ Group:_____ Clinic –Yes ☐ No ☐

Patient Information: (Patient to complete)*

*Patient Name: _____*Date of Birth: _____ *Age: _____ *Phone# _____

*Address: _____ *City: _____ *State: _____ *Zip:_____

*Gender: M or F *Which vaccine(s) would you like to receive today? _____

*Medical Conditions: _____*Enter Weight if less than 110 lbs.: _____
FOR EMERGENCY USE ONLY

*Primary Care Physician (PCP): _____ *Dr. Phone: _____

*PCP address- City _____ State_____ Zip Code_____
Email Address _____

The following questions will help us determine which vaccines may be given today. If a question is not clear, please ask your pharmacist to explain it.	**Yes**	**No**	**Don't Know**
Are you sick today?			
Do you have a long term health problem with heart disease, lung disease, liver disease, asthma, kidney disease, metabolic disorder (e.g. diabetes), anemia or other blood disorders?			
Do you have allergies to medications, food (i.e. eggs), latex or any vaccine component (e.g. neomycin, formaldehyde, gentamicin, thimerosal, bovine protein, phenol, polymyxin, gelatin, baker's yeast or yeast)?			
Have you received any vaccinations or TB skin test, in the past 4 weeks?			
Do you have a history of fainting, particularly with vaccines?			
Have you ever had a serious reaction after receiving a vaccination?			
Do you have a neurological disorder such as seizures or other disorders that affect the brain, or other nervous system problems, or have had a disorder that resulted from a vaccine (e.g. Guillain-Barre Syndrome)?			
Do you have cancer, leukemia, AIDS, or any other immune system problem? Have you been diagnosed with rheumatoid arthritis, ankylosing spondylitis, or Crohn's disease? (in some circumstances you may be referred to your physician)			
In the past 3 months, have you taken medications that weaken your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or have you had X-ray/radiation treatments? (in some circumstances you may be referred to your physician)			
During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin, including antibodies, or an antiviral drug?			
Are you a parent, family member, or caregiver to a new born infant?			
For the Td or Tdap vaccine: Do you have a cut, injury, puncture or open wound that prompted you to get a tetanus shot?*			
For the Zostavax vaccine: Have you had a past reaction to gelatin or triple antibiotic ointment?			
For patients over 65 and patients that have a chronic condition such as Asthma or COPD, or Smoke: Have you received the Pneumococcal or "Pneumonia" vaccine?			
Has any physician or other healthcare professional ever cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a medical setting?*			
For women: Are you pregnant or could you become pregnant in the next three months?			
Did you bring your Immunization Record Card with you?			

Have you had the following vaccines?	**Yes**	**No**	**Don't Know**
• **Pneumococcal Vaccine-- you may need two different pneumococcal shots**			
• **Zoster/Shingles Vaccine**			
• **Whooping Cough (Tdap) Vaccine**			

* *An immunization must not be given if there is an affirmative answer to these questions*

I authorize the pharmacist to send copies of my vaccine documents to my primary care provider. Yes ☐ No ☐
Failure to select one of these boxes will result in the vaccine documents being sent to my primary care provider, if known, as state laws & regulations require for my state.

- I acknowledge that if my insurance does not cover the cost of administering the vaccine at the pharmacy, then payment must be made at the time of the administration of the vaccine.
- I acknowledge that my vaccination record may be shared with federal or state or city agencies for registry reporting.
- I acknowledge that the pharmacist recommends that vaccinated patients should remain in the waiting area, for 20 minutes, after the administration of the immunization.
- I acknowledge that the administration of an immunization or vaccine does not substitute for an annual check-up with the patient's primary care physician.

Patient Signature or legal guardian signature: _____Date: _____

If under the age of 18, parent or legal guardian print name: _____

PHARMACY USE ONLY

☐ Influenza Injectable	☐ Meningococcal	☐ Zoster (Shingles)
☐ Pneumococcal	☐ Td	☐ Tdap
☐ Hepatitis B	☐ Hepatitis A	☐ Hepatitis A & B
☐ HPV	☐ MMR	☐ Hib:
☐ Varicella	☐ DTaP:	☐ Other:
☐ IPV:	☐ Other:	

Place RX Label Here

Place RX Label Here

Lot #_____
Exp. Date _____
Site RA or LA- Circle One

Lot #_____
Exp. Date_____
Site RA or LA- Circle One

Signature of pharmacist who administered Vaccine(s) and provided VIS to patient: _____

License #: _____ NPI: _____ Date: _____