Weinstein Pharmacy Immunization Questionnaire and Screening Consent Form

	No	Yes	If Yes, please explain below
1. Are you sick today?	☐	☐	_____
2. Do you have allergies to food (eggs), medications, a vaccine component, or latex?	☐	☐	_____
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☐	_____
4. Do you have cancer, leukemia, AIDS, or any other immune system problem?	☐	☐	_____
5. Do you take cortisone, prednisone, or other steroids, or anti-cancer drugs, or have you had any radiation therapy?	☐	☐	_____
6. Have you had a seizure or a brain or other nervous system problem?	☐	☐	_____
7. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	_____
8. For women: Are you pregnant or is there a chance you could become pregnant during the next 3 months?	___No	___Yes	
9. Have you received any vaccinations in the past 4 weeks?	☐	☐	_____
10. 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?	☐	☐	_____

Your signature below indicates that you have read and understand the Centers for Disease Control Vaccine Information Statement provided and the explained risks of receiving the vaccine. You understand that immunization can cause minor side effects such as redness, swelling, itchiness, mild fever and pain at the injection site. On rare occasions the vaccine can cause adverse reaction such as difficulty breathing, hoarseness, hives, paleness, weakness, fast heart rate, or dizziness. These symptoms happen within minutes of vaccine administration and should be reported to the nurse immediately. Please contact your primary care provider and go to the nearest emergency room if you experience any of these symptoms once you have left the clinic.

SSN_____ (Required) Your Age:_____ Date of Birth_____

Legal First Name)_____**Last Name**_____MI_____

Address_____City_____State_____ Zip_____

Ph:(C)_____(H)_____Signature_____Today's Date_____

Under 18 Legal guardian (print name)_____Relation to patient_____

Primary Insurance Subscriber First Name_____Last Name_____DOB_____ Gender: M F

___I authorize Weinstein Pharmacy to provide my medical records to my providers and other individuals as needed. Please fax my records to provider listed below:

Primary Care Doctor First name_____Last name_____Ph:_____

Department of Health Hepatitis C Screening Questionnaire:

1. Were you born between the years 1945 – 1965? ___No ___Yes
2. Did you receive donated blood or donated organs before 1992 and/ or blood clotting products before 1987? ___No ___Yes
3. Have you ever used injection drugs even once? ___No ___Yes

If you answered Yes to any of these questions, get tested for Hep C.

********** **FOR NURSES AND PHARMACISTS USE ONLY (PRINT ALL INFO CLEARLY)** **********

Date	Vaccine	Site/Route	MFR/Lot #	Series of Doses	VIS Given	Administered By
		LA RA IM SQ		Today is 1st 2nd 3rd of _____doses	Dated:	
		LA RA IM SQ		Today is 1st 2nd 3rd of _____doses	Dated:	
		LA RA IM SQ		Today is 1st 2nd 3rd of _____doses	Dated:	
		LA RA IM SQ		Today is 1st 2nd 3rd of _____doses	Dated:	
		LA RA IM SQ		Today is 1st 2nd 3rd of _____doses	Dated:	
		LA RA IM SQ		Today is 1st 2nd 3rd of _____doses	Dated:	