IMMUNIZATION SCREENING AND CONSENT

Updated July 2013

INFORMATION ABOUT PERSON TO RECEIVE VACCINE(S) (Please print clearly):

Last Name	First Name	Gender ☐ Male ☐ Female	Birth Date	Age
Address		City	State	Zip Code
Phone	Physician Name	Physician Address		
Method of Payment ☐ Self-Pay ☐ Insurance	Insurer Name (or BIN/PCN)	Group Number	Cardholder ID	

SCREENING QUESTIONS *Pharmacist: see box on reverse for additional screening considerations in children.*		**YES**	**NO**	**DON'T KNOW**
	1. Are you sick today? *[all vaccines]*	☐	☐	☐
	2. Do you have allergies to medications, food, a vaccine component or latex? *[all vaccines]*	☐	☐	☐
	3. Have you ever had a serious reaction after receiving this or any other vaccination? *[all vaccines]*	☐	☐	☐
	4. Have you had a seizure or a brain or other nervous system problem, including Guillain-Barre Syndrome? *[IIV/LAIV (GBS only), Td/Tdap]*	☐	☐	☐
	5. For women: are you pregnant or is there a chance you could become pregnant during the next month? *[LAIV, MMR, VAR, ZOS]*	☐	☐	☐
LIVE VACCINES ONLY	6. 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? *[LAIV]*	☐	☐	☐
LIVE VACCINES ONLY	7. Do you have cancer, leukemia, AIDS or any other immune system problem? *[LAIV, MMR, VAR, ZOS]*	☐	☐	☐
LIVE VACCINES ONLY	8. In the past 3 months have you taken cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments? *[LAIV, MMR, VAR, ZOS]*	☐	☐	☐
LIVE VACCINES ONLY	9. In the past year have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? *[LAIV, MMR, VAR, ZOS]*	☐	☐	☐
LIVE VACCINES ONLY	10. Have you received any vaccinations in the past 4 weeks? *[LAIV, MMR, VAR, ZOS, yellow fever]*	☐	☐	☐

CONSENT Please read and sign in the space provided below.

I hereby give my consent to the staff of Smith's Pharmacy to administer the vaccine(s) indicated below. I have read the Vaccine Information Sheet(s) (VIS) for my vaccine(s) and understand the benefits and risks of the vaccine and choose to assume that risk. As with all medical treatment, there is no guarantee that I will not experience an adverse side effect from the vaccine(s). I fully release and discharge the standing orders physician, and Kroger Limited Partnership I, dba Smith's Pharmacy, its affiliates and their officers, directors, and employees from any liability for illness, injury, loss, or damage which may result there from. I acknowledge that I have received a copy of the Kroger Company privacy policies, in accordance with HIPAA. I hereby assign payment of authorized insurance benefits due to me to be paid directly to Smith's Pharmacy. I hereby consent to the release of medical information when necessary for billing, reimbursement and medical protocol including applicable state immunization information systems. I understand that a photocopy of this release is as valid as the original. I am aware of the pharmacy's policy that billing to insurance on my behalf is a courtesy provided by them and that I am responsible for any deductible or co-insurance amount.

I agree to wait near the vaccination area for approximately 20 minutes to receive treatment in case of adverse reaction.

X_____ _____

Signature of Patient or Parent/Legal Guardian — Date

****PHARMACY USE ONLY****

Vaccine: _____	Vaccine: _____	Vaccine: _____
Brand: _____	Brand: _____	Brand: _____
Lot#.: _____ Exp: _____	Lot#.: _____ Exp: _____	Lot#.: _____ Exp: _____
Dose: _____ Route: IM SQ	Dose: _____ Route: IM SQ	Dose: _____ Route: IM SQ
Site of Administration: L_____ / R_____	Site of Administration: L_____ / R_____	Site of Administration: L_____ / R_____
Immunizer: _____ RPh / Intern	Immunizer: _____ RPh / Intern	Immunizer: _____ RPh / Intern
VIS Date: ____/____/____	VIS Date: ____/____/____	VIS Date: ____/____/____
Administration Date: ____/____/____	Administration Date: ____/____/____	Administration Date: ____/____/____

Background Information on Screening Questions

Refer to Epidemiology and Prevention of Vaccine Preventable Diseases *– the CDC "Pink Book" – for more information.*

1. Are you sick today? *[all vaccines]*

Based on the existing evidence, acute illness does not reduce vaccine efficacy nor increase vaccine adverse events. In the case of moderate or severe illness, all vaccines should be delayed until symptoms improve. In the case of mild illness, including upper respiratory infections or diarrhea, vaccine should NOT be delayed. Also, there is no need to delay vaccine if a person is taking antibiotics.

2. Do you have allergies to medications, food, a vaccine component or latex? *[all vaccines]*

- **Egg**: Can the person eat lightly cooked eggs such as scrambled eggs? If yes, administer **injectable influenza vaccine (IIV)**. If they get hives after eating eggs or egg-containing foods, administer IIV and observe the person for at least 30 minutes. If after eating eggs a person has a systemic or anaphylactic reaction, do not administer any type of influenza vaccine. Refer them to an allergist for further evaluation.
- **Gelatin**: If a person has anaphylaxis after eating gelatin, do not administer **MMR**, **varicella or live attenuated influenza vaccine (LAIV)** vaccine.
- **Gentamicin:** If a person has anaphylaxis after receiving gentamicin, do not administer **LAIV** vaccine.
- **Arginine:** If a person has anaphylaxis after taking arginine, do not administer **LAIV** vaccine.
- **Latex or other vaccine components:** Refer to Pink Book Appendix B for tables on latex-containing vials/syringes, as well as a complete list of vaccine components.

3. Have you ever had a serious reaction after receiving this or any other vaccination? *[all vaccines]*

Anaphylactic reaction to a vaccine or vaccine component is a contraindication for subsequent doses. If a precaution is present, vaccine should be deferred, unless the benefit outweighs the risk (e.g. during a community pertussis outbreak).

4. Have you had a seizure or a brain or other nervous system problem? *[IIV/LAIV (GBS only), Td/Tdap]*

- **Tdap** is contraindicated in those with a history of encephalopathy within 7 days of receiving DTP/DTaP given before the age of 7. Tdap should be deferred in those with unstable progressive neurologic problems. For those with stable neurologic disorders (e.g. seizures) unrelated to vaccination, or for people with family history of seizure, vaccinate as usual.
- A history of Guillain-Barre Syndrome (GBS) should be determined with Td/Tdap and influenza vaccines.
  - **Td/Tdap:** if GBS occurred within 6 weeks of a tetanus-containing vaccine and decision is made to go ahead with vaccine give Tdap instead of Td if no history of prior Tdap.
  - **Influenza:** if GBS occurred within 6 weeks of a prior influenza vaccine and decision is made to go ahead with vaccine (high risk for severe influenza complications), give IIV, not live attenuated influenza vaccine (LAIV).

5. For women: are you pregnant or is there a chance you could become pregnant during the next month? *[LAIV, MMR, VAR, ZOS]*

- **Live vaccines** (LAIV, MMR, VAR, ZOS) are contraindicated one month before pregnancy and throughout pregnancy. Sexually active females in their childbearing years should be counseled on careful contraception for one month after receiving a live vaccine.
- **Inactivated poliovirus vaccine** should not be given during pregnancy unless the patient is at high risk of contracting the disease (e.g. travel to endemic areas).
- A **Tdap** dose should be administered between 27 and 36 weeks gestation in each pregnancy, irrespective of the patient's prior history of Tdap

6. 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? *[LAIV]*

People with any of these health conditions should not receive **LAIV**. Administer IIV instead.

7. Do you have cancer, leukemia, AIDS or any other immune system problem? *[LAIV, MMR, VAR, ZOS]*

- Immunocompromised people should not receive **LAIV.** Also, those in close contact with severely immunocompromised individuals (those requiring protective isolation) should not receive LAIV. They should receive IIV instead.
- **Live vaccines** are usually contraindicated in immunocompromised patients, with certain exceptions, such as in patients with CD4+ T-lymphocyte counts of 200 cells/μL. In these patients MMR vaccine is recommended and varicella vaccine should be considered.

8. In the past 3 months have you taken cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments? *[LAIV, MMR, VAR, ZOS]*

- **Live vaccines** should be deferred for at least 3 months after chemotherapy treatments have ended. Live vaccines should also be delayed until after therapy with long-term high-dose steroid therapy has ended (>20 mg/day or >2mg/kg oral/IV prednisone for >14 days).
- **LAIV** should not be administered to anyone but healthy, non-pregnant people from ages of 2 to 49.

9. In the past year have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? *[LAIV, MMR, VAR, ZOS]*

- Certain **live vaccines** may need to be deferred. Consult the most recent ACIP recommendations for details.
- Antiviral drugs active against the herpes virus (e.g. acyclovir, famciclovir, valacyclovir) should be discontinued 24 hours before receiving **varicella** or **zoster** vaccines and should also be avoided until 14 days after vaccination.
- **LAIV** should not be administered to anyone but healthy, non-pregnant people from ages of 2 to 49. LAIV should not be administered until 48 hours after stopping therapy with anti-influenza drugs such as amantadine, rimantadine, zanamivir, and oseltamivir. These drugs should also be avoided for 14 days after vaccination.

10. Have you received any vaccinations in the past 4 weeks? *[LAIV, MMR, VAR, ZOS, yellow fever]*

If the patient has received a live vaccine in the past 4 weeks, 28 days must pass before they receive another live vaccine. Inactivated vaccines not administered simultaneously may be given at any spacing interval relative to other live or inactivated vaccines.

Additional screening considerations in children:

LAIV

- If the child is taking **long-term aspirin therapy** they should not receive **LAIV**. They should receive IIV instead.
- If the child is **between 2 and 4** and a health care provider determined the child had **wheezing or asthma** in the past 12 months, the child should NOT receive **LAIV**. They should receive IIV instead.

Rotavirus vaccine

If the child is a **baby** and has been told they had **intussusception**, they should not receive the **rotavirus** vaccine.

MMRV vaccine

If the child has a **history (or a parent or sibling with a history) of seizure**, they should not receive **MMRV**. They should receive MMR and varicella vaccines separately instead.