IMMUNIZATION SCREENING AND CONSENT

Albuquerque Public Schools Vaccine Clinics
Updated August 2014

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	

I AM INTERESTED IN RECEIVING THE FOLLOWING VACCINE(S) TODAY (Check all that apply):

☐ Flu ☐ Tetanus-Whooping Cough (Tdap) ☐ Pneumococcal

	SCREENING QUESTIONS	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: **INFLUENZA**	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: **08/19/2014**	VIS Date: ____/____/____	VIS Date: ____/____/____
Administration Date: ____/____/____	Administration Date: ____/____/____	Administration Date: ____/____/____