Wegmans Pharmacy Informed Consent/Screening Questionnaire for Immunizations NJ

Name: _____ Date of Birth: _____ Age: _____ Gender: _____ Phone # _____

Address: _____ City _____ State: _____ Zip: _____ Allergies: _____

Type of vaccine needed: _____ Primary Care or other Physician: _____ Physician Address:_____

Screening Questionnaire for Vaccination

The following questions help us determine which vaccines you may be given today. If you answer "Yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your pharmacist to explain it.

		YES	NO	UNKNOWN
1.	*Is the person to be vaccinated sick today?*	☐	☐	☐
2.	*Does the person to be vaccinated have an allergy to medications, food, a vaccine component, or latex?*	☐	☐	☐
3.	*Has the person to be vaccinated ever had a serious reaction after receiving a vaccination?*	☐	☐	☐
4.	*Has the person to be vaccinated had a seizure or a brain or other nervous system problem, including Guillan-Barré syndrome?*	☐	☐	☐
5.	*Does the person to be vaccinated have cancer, leukemia, HIV/AIDS, or any other immune system problem?*	☐	☐	☐
6.	***Females only**: Is the person to be vaccinated pregnant or is there a chance they could become pregnant during the next month?*	☐	☐	☐

Answer Questions 7-11 ONLY if the person to be vaccinated is <18 years old OR is receiving a live attenuated vaccine (includes Measles Mumps Rubella (MMR), Varicella, or FluMist [the nasal influenza vaccine]).

7.	*In the past 3 months, has the person to be vaccinated taken medications that weaken the immune system, such as cortisone, prednisone, other steroids, biologic medications (such as Enbrel, Humira, Orencia), or anticancer drugs, or have they had radiation treatments?*	☐	☐	☐
8.	*During the past year, has the person to be vaccinated received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug (including influenza antiviral medications)?*	☐	☐	☐
9.	*Has the person to be vaccinated received any other vaccinations in the past 4 weeks?*	☐	☐	☐
10.	*Is the person to be vaccinated receiving aspirin therapy or aspirin-containing therapy (<18 years old only)?*	☐	☐	☐
11.	*For children 2-4 years old receiving FluMist: Does the child have a history of wheezing or asthma?*	☐	☐	☐

Answer Questions 12-14 ONLY if the person to be vaccinated is <18 years old.

12. *Weight of person to be vaccinated (lbs)*_____

13.	*Does the person to be vaccinated have a long-term health problem with heart disease, lung disease (including asthma), kidney disease, neurologic disease, liver disease, metabolic disease (e.g. diabetes), or anemia or other blood disorder?*	☐	☐	☐
14.	*If the person to be vaccinated is **less than or equal to 8 years old**, have they received **two doses of an influenza vaccine** in the past?*	☐	☐	☐

I have read, or have had read to me, the Vaccine Information Statement (VIS) developed by the Centers for Disease Control and Prevention (CDC) given with this Consent. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks (including potential side effects and adverse reactions) of the vaccine(s). I consent to, or give consent for, the administration of the vaccine(s) marked below.

☐ **I authorize my vaccination documentation to be forwarded to my primary care/other physician.**

☐ **I do not authorize my vaccination documentation to be forwarded to my primary care/other physician.**

I understand and agree that if I fail to select either option 1 or 2 above that my vaccination documentation will be sent to my primary care or other physician, if identified above. I authorize my vaccination documentation to be forwarded to the collaborative prescribing physician for this program and/or the applicable State/Commonwealth Department of Health or its equivalent. I understand that it is recommended that I stay in the general area for 15 to 20 minutes after receiving my vaccination in case any immediate reactions occur. I understand that if I experience any side effects, it will be my responsibility to follow up with my physician at my expense. I hereby release the collaborative prescribing physician for this program, Wegmans Food Markets, Inc., its subsidiaries, affiliates, officers, employees and agents, from any and all liability that might arise from this vaccination on behalf of me, my heirs and personal representatives. I have been provided with a copy of the Wegmans Notice of Privacy Practices. I have been given a copy of this Consent form. Your health is very important to us. Regular preventative care, including vaccines such as the flu shot, can protect you and your family. From time to time, Wegmans Pharmacy may have helpful information regarding services that may be of interest to you. By signing below, I consent to receive healthcare communications from Wegmans Pharmacy at the telephone number(s) listed above regarding the available vaccines, my prescription(s) and those of my dependent minors, and as a follow up to care that I have received or that my dependent minors have received.

Store Stamp here (place on both copies)

✕

Patient Signature or Legal Representative Relationship of Legal Representative to Patient (if applicable) Date

By signing on this line, I acknowledge that I have received the immunizations listed below and authorize the release of claim information to any third party agencies involved.

*****For Pharmacy Use Only*****

Vaccine Name	Dose (mL)	Vaccine Information			Route (IM/SQ/IN)	Site Given (RA/LA)	Date on VIS	Admin Date / Date VIS Given to Patient
		Lot	Expiration	Manufacturer				

Form and Questions have been reviewed by Immunizer: **Administering/Supervising Pharmacist Signature:** _____ **RPH**

Intern Signature (if applicable): _____