Updated 08/17/2020

Screening & Consent for Inactivated Injectable Vaccinations

Not for use with live vaccines such as MMR, Varicella, Zostavax, FluMist, or Oral Typhoid

Name: ______________________ DoB: __________ Phone: ______________

Address: ____________________ City: ______________ State: ________ Zip: ________

Allergies: __________ Insurance *BIN:* ________ *PCN:* ________ *Group:* ________ *ID:* ________

Primary Care Provider: ____________________ Phone: ____________ Fax: ____________

[ ] I **DO NOT** have a primary care provider or am unable to provide their contact information

Screening Questions *If a question is not clear, please ask the pharmacist to explain it.*

		Yes	No	Don't Know
Health Screening	1. Are you sick today?			
	2. Have you had any COVID-19 symptoms in the past 14 days including: • Cough • Muscle or body aches • Sore throat • Headache • Diarrhea • Fever >100.4°F • Chills • New loss of taste or smell • Congestion or runny nose • Unexpected shortness of breath • Fatigue • Nausea or vomiting ***(circle all that apply)***			
	3. Have you had, or have you been in contact with anyone with, confirmed or suspected Coronavirus (COVID-19) infection within the past 14 days?			
****STOP:** If you answered yes to any of the above questions, speak with the pharmacist before completing this form**				
Vaccine History	4. Do you Smoke?			
	5. Do you have Asthma, Diabetes, or Heart Disease?			
	6. Have you ever had a Pneumonia vaccine? If so, When? ___________			
	7. Have you ever had a Shingles vaccine? If so, When? ___________			
	8. When was your most recent Tetanus shot? ___________			
All Vaccines	9. Do you have a serious allergy to any vaccine component? (Examples: Eggs, Gelatin, Thimerosal, Neomycin, Gentamicin, Latex) *If Yes, please list:* ______________________			
	10. Have you ever had a serious reaction or fainted after receiving any vaccination?			
	11. Do you have a seizure or brain disorder or other nervous system problem?			

I acknowledge that I understand the benefits and risks of the requested vaccination as described in the Vaccine Information Sheet, a copy of which is provided with this Consent and Release. I confirm that Save Mart/Lucky Supermarkets on behalf of its Pharmacy operations in all divisions has answered to my satisfaction all of my questions about the vaccine and the vaccination procedure. I request and consent that the vaccination be given, as I direct Save Mart/Lucky, either to me or to the person named above a minor for whom I represent that I am authorized to sign this Consent and Release. I understand that I am giving Save Mart/Lucky permission to release any medical or other information necessary to my physician, Medicare, Medicare HMO, or Insurance company or immunization registry, as applicable, to enable Save Mart/Lucky to process my insurance claims with respect to the vaccination. I, for myself (and for the recipient of the vaccination, if the recipient is a minor), my heirs, executors and assigns hereby release Save Mart/Lucky and its divisions and affiliates and their respective officers, directors, employees, agents, and representatives from any and all claims arising out of or in connection with the quality of the above-described vaccine(s) as provided by the manufacturer and any negligence of Save Mart/Lucky in connection with the related injection of the vaccination. I understand that the laws of my state may affect my remedies in connection with this vaccination.

X		
Signature of Person to Receive Vaccine / Parent or Guardian of Minor	Date	Print name of Parent or Guardian and Phone Number

*****************************Below Line For Pharmacist Use Only*******************************

Vaccine	Lot #	Exp Date	Mfr	Dosage	Injection Site	Time	Date on VIS
Influenza QIV				0.5 mL	IM L / R Deltoid		
Influenza HD				0.7 mL	IM L / R Deltoid		
Shingrix				0.5 mL	IM L / R Deltoid		
Pneumovax 23				0.5 mL	IM L / R Deltoid		
Prevnar 13				0.5 mL	IM L / R Deltoid		
Tdap				0.5 mL	IM L / R Deltoid		
Pharmacist Signature:					Date VIS provided to patient:		

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