Vaccine Screening and Consent
Rosauers Pharmacy

Name: Date of birth: Age: Gender:

Address: City: State: ZIP:

Phone number: Race: Ethnicity:

Medication allergies:

PATIENT SCREENING QUESTIONS FOR ALL VACCINATIONS		
Are you feeling sick today? If yes, please explain:	Yes	No
Do you have allergies to any vaccine or vaccine component (eggs, gelatin, thimerosal, neomycin or gentamicin, food, adhesives or latex? If yes, explain allergy:	Yes	No
Have you ever had a serious reaction to ANY vaccine in the past?	Yes	No
Have you ever had a seizure, brain disorder, nervous system problem or Guillain Barré syndrome?	Yes	No
Have you ever felt dizzy or faint before, during, or after a shot?	Yes	No
If female, are you pregnant or do you plan to become pregnant?	Yes	No
PATIENT SCREENING QUESTIONS FOR COVID-19 VACCINATIONS ONLY		
Do you have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised?	Yes	No
Have you ever had an allergic reaction to a component of a COVID-19 vaccine or previous dose of COVID-19 vaccine?	Yes	No
Have you received a COVID-19 vaccine before or during hematopoietic cell transplant or CAR-T-cell therapies?	Yes	No

Have you ever had a history of? Check all that apply:

- ☐ Myocarditis or pericarditis
- ☐ COVID-19 disease within the past 3 months?
- ☐ Multisystem Inflammatory Syndrome
- ☐ Vaccinated with monkeypox vaccine in the last 4 weeks?
- ☐ History of thrombosis or thrombocytopenia (TTS) or Immune-mediated syndrome such as heparin induced thrombocytopenia (HIT)

Are you up to date on all your vaccinations?			
Has it been more than ten years since your last tetanus shot?	Yes	No	N/A
Patients over 65, have asthma, diabetes, or heart disease, have you received a pneumonia shot?	Yes	No	N/A
Patients over 60, have you received the RSV shot?	Yes	No	N/A
Patients over 50 have you received the shingles shot(s)?	Yes	No	N/A

CONSENT

I have read, or have had read to me, the written information regarding the vaccine(s) being administered. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) being administered and have received a copy of a current Vaccine Information Sheet prior to vaccine(s) being administered. I, on behalf of myself, my heirs, executors, personal representatives, agents, successors, and assigns hereby agree to release, indemnify, and hold harmless Rosauers, its subsidiaries, divisions, affiliates, agents, officers, directors, contractors, and employees from any and all claims arising out of, in connection with, or in any way related to the administration of the vaccine(s). I certify that I am at least 18 years old and hereby give my consent to the pharmacists of this location to administer the vaccine(s). If under 18 years old signature by parent or guardian is required. I agree to wait in the pharmacy waiting area for approximately 15 minutes for observation by the pharmacist. I acknowledge that my vaccination record may be shared with federal or state agencies for registry reporting.

Name (print) ____________________ **Signature** ____________________ **Date** ____________

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Pharmacist Use Only

Vaccine	Manufacturer	Dose	Site of Injection	VIS date	Lot number and Exp date
Influenza	Sanofi GSK Seqirus	0.5 ml 0.7ml	LD RD	8/6/2021	
Herpes Zoster	GSK	0.5 ml	LD RD	2/4/2022	
RSV	GSK	0.5 ml	LD RD	7/24/2023	
Tdap	GSK	0.5 ml	LD RD	8/6/2021	
Covid-19			LD RD	☐ **EUA given**	☐ **Immunization Card Given**
Other			LD RD		

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Substitutions Permitted

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Dispense As Written

Keep for 10 years!
File with prescription hard copies

PharmD/Rph Technician Intern

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Signature and title of administrator (circle one)

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Date