SENATE HEALTH & WELFARE COMMITTEE
Wednesday, February 17, 2016

ATTACHMENT 2

DOUG

Patient Name:	Date of Birth:
Address:	Patient Phone:
Primary Doctor:	Ins ID#:

Screening Checklist for Contraindications to Vaccines

Patients: The following questions will 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	Don't Know
1. Are you sick today?			
2. Do you have allergies to medications, food, a vaccine component or latex?			
3. Have you ever had a serious reaction after receiving a vaccination?			
4. 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?			
5. Do you have cancer, HIV, leukemia or any other immune system problem?			
6. In the past 3 months, have you taken medications that weaken your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?			
7. Have you had a seizure, brain disorder or other nervous system problem?			
8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or antiviral drug?			
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?			
10. Have you received any vaccinations in the past 4 weeks?			
11. **Did you bring your immunization record card with you today?** It is important to have a personal record of all of your vaccinations. If you don't have one, request one from your healthcare provider.			

I agree that the person named above will receive the vaccine indicated and that this person will have a vaccine put in his or her body to prevent infectious disease. I received a copy of the Vaccine Information Sheet. I know the risks of the disease this prevents and the benefits and risks of the vaccine. I have had a chance to ask questions about the disease and vaccine. I understand a record will kept of this vaccination, and that a summary may be sent to my primary care physician, Idaho's Immunization Reminder System, daycares and schools. I voluntarily give my signed permission for this vaccine to be given. I can review this information upon request. I have received information about HIPPA.

Patient/Rep Signature:_____ Date:_____

Form reviewed by:_____ Date:_____

We just have the parent sign here as representative

Clinic –Yes ☐ No ☐

RITE AID PHARMACY

With us, it's personal.

Screening Questionnaire and Consent Form

Patient Information: (Patient to complete)*

*Patient Name: _____ *Date of Birth: _____ *Age: _____ *Phone# _____

*Address: _____ *City: _____ *State: _____ *Zip: _____

*Gender: M or F *Which vaccine(s) would you like to receive today? _____

*Medical Conditions: _____ *Enter Weight if less than 110 lbs.: _____
FOR EMERGENCY USE ONLY

*Primary Care Physician (PCP): _____ *Dr. Phone: _____

*PCP address- City _____ State_____ Zip Code_____

Email Address _____

_____

The following questions will help us determine which vaccines may be given today. If a question is not clear, please ask your pharmacist to explain it.	**Yes**	**No**	**Don't Know**
Are you sick today?			
Do you have a long term health problem with heart disease, kidney disease, metabolic disorder (e.g. diabetes), anemia or other blood disorders?			
Do you have a long term health problem with lung disease or asthma? Do you smoke?			
Do you have allergies to medications, food (i.e. eggs), latex or any vaccine component (e.g. neomycin, formaldehyde, gentamicin, thimerosal, bovine protein, phenol, polymyxin, gelatin, baker's yeast or yeast)?			
Have you received any vaccinations in the past 4 weeks?			
Have you ever had a serious reaction after receiving a vaccination?			
Do you have a neurological disorder such as seizures or other disorders that affect the brain or have had a disorder that resulted from a vaccine (e.g. Guillain-Barre Syndrome)?			
Do you have cancer, leukemia, AIDS, or any other immune system problem? (in some circumstances you may be referred to your physician)			
Do you take prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?			
During the past year, have you received a transfusion of blood or blood products, including antibodies?			
Are you a parent, family member, or caregiver to a new born infant?			
For children receiving FluMist®: Do you receive long term aspirin therapy or have a history of wheezing (2-4yo)?			
For women: Are you pregnant or could you become pregnant in the next three months?			
Did you bring your Immunization Record Card with you?			
Have you had the following vaccines:	**Yes**	**No**	**Don't Know**
• **Pneumococcal Vaccine-- *you may need two different pneumococcal shots***			
• **Shingles Vaccine**			
• **Whooping Cough (Tdap) Vaccine**			

Albertson's

2015-2016 Informed Consent to Receive Vaccines

List your name exactly as it appears on your Medicare or other insurance card. Provide the date of birth and street address that your insurance has on file for you. Providing incorrect information may cause your insurance to reject payment.

PATIENT INFORMATION

First Name: _____ **Last Name:** _____ **Date of Birth:**

Street Address: _____ **Age:** _____

City: _____ **State:** _____ **Zip:** _____

Phone: (_____) _____ **Male / Female (circle one)**

Drug Allergies: _____

When did you last receive the following vaccines?

Hepatitis B	Date / /	Never/Unsure	Tetanus	Date _/_/_	Never/Unsure
Influenza (flu)	Date / /	Never/Unsure	Whooping cough	Date _/_/_	Never/Unsure
Pneumonia	Date / /	Never/Unsure	Other	Date _/_/_____	Never/Unsure
Shingles	Date / /	Never/Unsure			

PHYSICIAN INFORMATION

Do you have a Primary Care Physician? **Yes** **No** **(circle one)**

Physician: _____ **Physician Phone: (_____)** _____

Physician Address: _____

INSURANCE INFORMATION

Important Notice: Immunizations may or may not be covered by your insurance. We will verify eligibility under your plan and attempt to collect payment from your insurance for all immunizations. If we are unable to confirm eligibility, **you may still opt to receive it at our pharmacy and pay for it yourself** or your insurance may cover administration of the vaccine by your physician. **You are responsible for payment for products or services you receive that are not paid for by your plan.** Please provide your insurance information below.

Note for patients with Medicare: To receive the flu vaccine at no charge at the pharmacy, you must have traditional **Medicare Part B, Railroad Medicare, or select Medicare HMO plans**. If you have a **Medicare HMO plan,** it must be a plan that has contracted with the pharmacy to provide immunizations.

Insurance name (i.e. Medicare B, Aetna, etc.):

ID # (include any letters): _____ Group #:

PLEASE INITIAL THAT YOU HAVE READ AND UNDERSTAND THE INFORMATION ABOVE _____

I have read, or have had read to me, the provided Vaccine Information Statement(s) ("VIS"). I have had the opportunity to ask questions about the vaccine(s), and all my questions have been answered to my satisfaction. I understand the benefits and risks of the vaccine(s). I consent to the administration of the vaccine(s) requested. I understand that my receipt of this vaccination is subject to reporting, by my pharmacy or its business associate, to an immunization registry, which may share my immunization data with others, and to my primary care physician, the authorizing physician, or the local Dept. of Health, if applicable, and I authorize these disclosures. I agree to stay in the general area for 15 minutes after receiving my vaccination in case any immediate reactions occur. I understand that if I experience any side effects, I am responsible for following up with my physician at my expense. On behalf of myself, my heirs, and my personal representatives, I hereby release the pharmacy that is administering the vaccine(s); New Albertson's Inc., Albertson's LLC and their subsidiaries and affiliates; the respective directors, officers, employees, and agents of New Albertson's Inc., Albertson's LLC and their subsidiaries and affiliates; and the owner and/or operator of the clinic site and its directors, officers, employees, and agents from any and all liability and claims that might arise from this vaccination.

Please initial that you received our HIPAA Notice of Privacy Practices

_____ (initials)

_____ _____

Patient/Parent/Guardian Signature **Date**

COSTCO PHARMACY

Immunization Consent Form

PATIENT'S LAST NAME | PATIENT'S FIRST NAME | MI | GENDER (M/F)

ADDRESS | CITY | STATE | ZIP

10-DIGIT PHONE NUMBER | MEDICARE ID NUMBER | BIRTH DATE (MM/DD/YYYY)

PRIMARY HEALTHCARE PRESCRIBER | PRESCRIBER ADDRESS | PRESCRIBER PHONE/FAX | VACCINE REQUESTED

PRECAUTIONS AND CONTRAINDICATIONS (Please check yes or no for each question.)

1. Are you sick today? ❒ Yes ❒ No
2. Do you have allergies to medications, food or vaccines? ❒ Yes ❒ No
   Allergies _____
3. Have you ever had a serious reaction after receiving a vaccination? ❒ Yes ❒ No
4. 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? ❒ Yes ❒ No
5. Do you have cancer, leukemia, AIDS or any other immune system problem? ❒ Yes ❒ No
6. Do you take cortisone, prednisone, other steroids or anti-cancer drugs, or have you had X-ray treatments? ❒ Yes ❒ No
7. Have you had a seizure, brain or nerve problem? ❒ Yes ❒ No
8. During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin? ❒ Yes ❒ No
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month? ❒ Yes ❒ No
10. Have you received any vaccinations in the past 4 weeks? ❒ Yes ❒ No
    If yes, what vaccines? _____
11. Are you allergic to eggs? ❒ Yes ❒ No
12. Are you allergic to latex? ❒ Yes ❒ No

ADVERSE REACTIONS

A vaccine, like any medicine, is capable of causing serious problems, such as severe allergic reactions. The risk of any vaccine causing serious harm, or death, is extremely small.

Local symptoms may include: slight tenderness, redness, itching or swelling at the site of injection.

Systemic symptoms may include: fever, malaise and muscle pain. Other systemic symptoms may occur infrequently. These reactions usually begin 6 to 12 hours after immunization and can persist for a few days. Immediate presumable allergic reactions such as hives, angioedema, allergic asthma or systemic anaphylaxis occur rarely after immunization. These reactions may result from hypersensitive reactions in people with severe egg allergy, and such people should not be given certain vaccines that contain eggs. People with documented immunoglobulin E (IgE)-mediated hypersensitivities to eggs or any other vaccine components, including thimerosal, may also be at increased risk of reactions from immunizations.

In the case of a severe reaction such as a high fever, behavior changes or flu-like symptoms that occur after vaccination, see a doctor right away. Signs of an allergic reaction can include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heartbeat, or dizziness within a few minutes to a few hours after the shot.

ADMINISTRATIVE RECORD FOR PHARMACY USE ONLY

VACCINE: _____ EXPIRATION DATE: _____	VACCINE: _____ EXPIRATION DATE: _____	VACCINE: _____ EXPIRATION DATE: _____
VIS VERSION: _____ SITE OF INJECTION: _____	VIS VERSION: _____ SITE OF INJECTION: _____	VIS VERSION: _____ SITE OF INJECTION: _____
MANUFACTURER: _____ DOSAGE: _____	MANUFACTURER: _____ DOSAGE: _____	MANUFACTURER: _____ DOSAGE: _____
LOT NUMBER: _____ ROUTE OF ADMIN: _____	LOT NUMBER: _____ ROUTE OF ADMIN: _____	LOT NUMBER: _____ ROUTE OF ADMIN: _____

PAYMENT INFORMATION FOR PHARMACY USE ONLY

VACCINE FEES | **TOTAL CHARGE**

"I have read the adverse reactions associated with the administration of vaccines. A copy of the vaccine manufacturer's drug information sheet is available on request. Furthermore, I have also had an opportunity to ask questions about these immunizations. I believe the benefits outweigh the risks and I voluntarily assume full responsibility for any reactions that may result from either my receipt of the immunization(s) or the receipt of the immunization(s) by the person named below for whom I am the legal guardian ("Ward"). My medical record may be shared with my physician or other healthcare provider and the medical record of my Ward may be shared with his/her physician or other healthcare provider. I am requesting that the immunization(s) be given to me or my Ward. I, for myself and on behalf of my Ward, and each of our respective heirs, executors, personal representatives and assigns, hereby release Costco, and its affiliates, subsidiaries, divisions, directors, contractors, agents and employees (collectively "Released Parties"), from any and all claims arising out of, in connection with or in any way related to my receipt and the receipt by my Ward of this or these immunization(s). Neither Costco nor any of the Released Parties shall, at any time or to any extent whatsoever, be liable, responsible or any way accountable for any loss, injury, death or damage suffered or sustained by any person at any time in connection with or as a result of this vaccine program or the administration of the vaccines described above. Costco will use and disclose your personal and health information or the personal and health information of your Ward, to treat you or your Ward, to receive payment of the care we provide, and for other health care operations. Healthcare operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regard to you and your Ward's personal health information. I acknowledge that I have received a copy of the Notice of Privacy Practices."

SIGNATURE/LEGAL GUARDIAN | DATE OF VACCINATION/DATE VIS GIVEN

PRINT NAME | PHARMACIST/PRESCRIBER SIGNATURE

PHARMACY NAME/ADDRESS

PLEASE PROVIDE A COPY OF THIS FORM TO YOUR PHYSICIAN AND/OR HEALTHCARE PROVIDER FOR YOUR PERMANENT MEDICAL RECORDS.

WHITE – ADMINISTRATIVE COPY YELLOW – PATIENT COPY

ACCREDITED Compounding Pharmacy

- Prescriptions
- Compounding
- FREE Delivery

Ladd
FAMILY PHARMACY
Caring for you and about you

- Wellness Classes
- FREE Mailing
- Billing Arrangements

ACCREDITED Compounding Pharmacy

Vaccine Administration Consent Form

I have been given the opportunity to ask questions about the vaccine listed below and my questions were answered to my satisfaction. I have received the appropriate CDC Vaccine Information Statement (VIS) and have read the information or had it read to me. I have received all the information I need to give this informed consent. I have never had a history of hypersensitivity or a life threatening allergic reaction to gelatin, neomycin or to any other component of the vaccine. I have never had a history of hypersensitivity or allergic reaction to dry natural latex rubber.

I understand the benefits, risks and contraindications to this vaccine. I understand, as with all medical treatments, there is no guarantee that I will become immune. I am not immunosuppressed, on hemodialysis, breastfeeding, or pregnant. I am not taking high dose corticosteroids or other immunosuppressive therapy. I do not have active tuberculosis. I will inform my health care provider if I have any current illness, infection or elevated temperature. I understand I may need to postpone the vaccination until I have recovered. I will inform my health care provider if I have received a vaccine or injection recently.

I understand that vaccines, like any medication, can cause mild side effects including soreness/redness at the injection site, fever, headache and body aches. Other reported side effects include bruising, itching at the injection site, diarrhea, runny nose, or rash. I understand that vaccines can in rare instances cause complications, including infection, allergic reaction and death. I also, understand that the chance of serious harm is very rare and that these vaccinations are FDA approved. I agree to accept this risk to decrease my chances of contracting a serious preventable disease. I understand to seek medical attention immediately if I have any difficulty breathing, swelling of the lips, wheezing, hoarseness, fast heart beat, hives, dizziness or swelling of the throat.

Vaccine to be administered: Influenza vaccine (FluLaval, Fluvirin, Flumist, Afluria), Pneumococcal (PneumoVax), or Zostavax

_____ _____ _____
Name of Patient (Please Print Clearly) Date of Birth AGE

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Legal Guardian Date

Please do not write below this line. **Ladd Family Pharmacy** Authorized personnel only

FluLaval Fluvirin Flumist Afluria	_____ Date	_____ Manufacturer Lot#, exp date	RD LD Injection Site	IM Route	_____ Initials
Pneumovax	_____ Date	_____ _____ Manufacturer Lot#, exp date	RD LD Injection Site	IM Route	_____ Initials
Zostavax	_____ Date	_____ _____ Manufacturer Lot#, exp date	RD LD Injection Site	SQ Route	_____ Initials

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INSURANCE BILLING OPTIONS FOR COMPOUNDING

Information for Health Professionals about the Screening Checklist for Contraindications To Vaccines for Adults

Are you interested in knowing why we included a certain question on the screening checklist? If so, read the information below. If you want to find out even more, consult the references listed at the bottom of this page.

1. Are you sick today? *[all vaccines]*
There is no evidence that acute illness reduces vaccine efficacy or increases vaccine adverse events (1). However, as a precaution with moderate or severe acute illness, all vaccines should be delayed until the illness has improved. Mild illnesses (such as upper respiratory infections or diarrhea) are NOT contraindications to vaccination. Do not withhold vaccination if a person is taking antibiotics.

2. Do you have allergies to medications, food, a vaccine component, or latex? *[all vaccines]*
If a person has anaphylaxis after eating gelatin, do not administer MMR or varicella vaccine. A local reaction to a prior vaccine dose or vaccine components (e.g., latex) is not a contraindication to a subsequent dose or vaccine containing that component. For a table of vaccines supplied in vials or syringes that contain latex, go to www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/latex-table.pdf. For an extensive list of vaccine components, see reference 2.
An egg-free recombinant influenza vaccine (RIV3) may be used in people age 18 years and older with egg allergy of any severity who have no other contraindications. People younger than age 18 years who have experienced a serious systemic or anaphylactic reaction (e.g., hives, swelling of the lips or tongue, acute respiratory distress, or collapse) after eating eggs can usually be vaccinated with inactivated influenza vaccine (IIV); consult ACIP recommendations (see reference 3).

3. Have you ever had a serious reaction after receiving a vaccination? *[all vaccines]*
History of anaphylactic reaction (see question 2) to a previous dose of vaccine or vaccine component is a contraindication for subsequent doses (1). Under normal circumstances, vaccines are deferred when a precaution is present. However, situations may arise when the benefit outweighs the risk (e.g., during a community pertussis outbreak).

4. 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]*
The safety of intranasal live attenuated influenza vaccine (LAIV) in people with these conditions has not been established. These conditions, including asthma in adults, should be considered precautions for the use of LAIV.

5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem? *[LAIV, MMR, VAR, ZOS]*
Live virus vaccines (e.g., LAIV, measles-mumps-rubella [MMR], varicella [VAR], zoster [ZOS]) are usually contraindicated in immunocompromised people. However, there are exceptions. For example, MMR vaccine is recommended and varicella vaccine should be considered for adults with CD4+ T-lymphocyte counts of greater than or equal to 200 cells/μL. Immunosuppressed people should not receive LAIV. For details, consult the ACIP recommendations (1, 4, 5).

6. In the past 3 months, have you taken medications that weaken your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments? *[LAIV, MMR, VAR, ZOS]*
Live virus vaccines (e.g., LAIV, MMR, VAR, ZOS) should be postponed until after chemotherapy or long-term high-dose steroid therapy has ended. For details and length of time to postpone, consult the ACIP statement (1, 3). To find specific vaccination schedules for stem cell transplant (bone marrow transplant) patients, see reference 6. LAIV can be given only to healthy non-pregnant people younger than age 50 years.

7. Have you had a seizure or a brain or other nervous system problem? *[Influenza, Td/Tdap]*
Tdap is contraindicated in people who have a history of encephalopathy within 7 days following DTP/DTaP given before age 7 years. An unstable progressive neurologic problem is a precaution to the use of Tdap. For people with stable neurologic disorders (including seizures) unrelated to vaccination, or for people with a family history of seizure, vaccinate as usual. A history of Guillain-Barré syndrome (GBS) is a consideration with the following: 1) Td/Tdap: if GBS has occurred within 6 weeks of a tetanus-containing vaccine and decision is made to continue vaccination, give Tdap instead of Td if no history of prior Tdap; 2) Influenza vaccine (IIV/LAIV): if GBS has occurred within 6 weeks of a prior influenza vaccine, vaccinate with IIV if at high risk for severe influenza complications.

8. During 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]*
Certain live virus vaccines (e.g., LAIV, MMR, VAR, ZOS) may need to be deferred, depending on several variables. Consult the most current ACIP recommendations for current information on intervals between antiviral drugs, immune globulin or blood product administration and live virus vaccines. (1)

9. For women: Are you pregnant or is there a chance you could become pregnant during the next month? *[MMR, LAIV, VAR, ZOS]*
Live virus vaccines (e.g., MMR, VAR, ZOS, LAIV) are contraindicated one month before and during pregnancy because of the theoretical risk of virus transmission to the fetus. Sexually active women in their childbearing years who receive live virus vaccines should be instructed to practice careful contraception for one month following receipt of the vaccine. On theoretical grounds, inactivated poliovirus vaccine should not be given during pregnancy; however, it may be given if risk of exposure is imminent and immediate protection is needed (e.g., travel to endemic areas). Use of Td or Tdap is not contraindicated in pregnancy. At the provider's discretion, either vaccine may be administered during the 2nd or 3rd trimester. (1, 3, 4, 5, 7, 8)

10. Have you received any vaccinations in the past 4 weeks?
[LAIV, MMR, VAR, yellow fever] People who were given either LAIV or an injectable live virus vaccine (e.g., MMR, VAR, ZOS, yellow fever) should wait 28 days before receiving another vaccination of this type. Inactivated vaccines may be given at any spacing interval if they are not administered simultaneously.

References:
1. CDC. General recommendations on Immunization. at www.cdc.gov/vaccines/pubs/acip-list.htm
2. Table of Vaccine Components: www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/excipient-table-2.pdf.
3. CDC. Prevention and control of seasonal influenza with vaccines: Recommendations of the ACIP—2014–2015 Influenza Season at www.cdc.gov/mmwr/pdf/wk/mm6332.pdf, pages 691–7.
4. CDC. Measles, mumps, and rubella—vaccine use and strategies for elimination of measles, rubella, and congenital rubella syndrome and control of mumps. *MMWR* 1998; 47 (RR-8).
5. CDC. Prevention of varicella: Recommendations of the Advisory Committee on Immunization Practices. *MMWR* 2007; 56 (RR-4).
6. Tomblyn M, Einsele H, et al. Guidelines for preventing infectious complications among hematopoletic stem cell transplant recipients: a global perspective. *Biol Blood Marrow Transplant* 15:1143–1238; 2009 at www.cdc.gov/vaccines/pubs/hematocell-transplts.htm.
7. CDC. Notice to readers: Revised ACIP recommendation for avoiding pregnancy after receiving a rubella-containing vaccine. *MMWR* 2001; 50 (49).
8. CDC. Prevention of pertussis, tetanus, and diphtheria among pregnant and postpartum women and their infants: Recommendations of the ACIP. *MMWR* 2008; 57 (RR-4).

Safeway

CONSENT AND RELEASE - INJECTABLE VACCINATIONS

Vaccine(s) Requested: **Injection Site:** LD RD LPLUA RPLUA

_____ ____/____/_____ (____) ☐ M ☐ F

Last Name of Patient First Middle Birth Date Age Gender

_____ (____)____-____

Permanent Address City State Zip Home Phone

_____/ _____ _____ _____

Primary Insurance Insurance ID # or Medicare B Number (Include numbers and letters) Primary Care Physician (Please provide if you want records sent to him/her) Phone #

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 Safeway Inc., on behalf of its pharmacy operations in all divisions, ("Safeway") 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 Safeway, 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 Safeway 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 Safeway 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 Safeway 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 Safeway 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(s)/Parent or Guardian of Minor Date Print Name of Parent or Guardian/ Phone #

By checking this box ☐ I authorize the administration of vaccine(s) by an immunization trained student pharmacist

		Please answer these questions by checking the boxes. If the question is not clear, please ask your pharmacist.	Yes	No	Don't Know
Vaccine History	1	All Patients: How long has it been since your last TETANUS shot?	___ yrs		☐
	2	Please check all that apply to you: ☐ Asthma ☐ Diabetes ☐ Heart Disease ☐ Tobacco Smoker ☐ 65 years or older If you checked any of the above, have you ever received the Pneumonia Vaccine? If yes, when?	☐	☐	☐
	3	Patients 60 years of age or older: Have you ever received the SHINGLES vaccine?	☐	☐	☐
All	4	Are you sick today?	☐	☐	☐
	5	Do you have a serious allergy to ANY medications or food? (Example: Eggs, Gelatin, Thimerosal, Neomycin, Gentamicin). If Yes, please list:	☐	☐	☐
	6	Have you ever had a serious reaction or fainted after receiving any vaccination?	☐	☐	☐
	7	Do you have sensitivity to latex? (Example: gloves or bandages)	☐	☐	☐
	8	For women: Are you pregnant or are you considering becoming pregnant?	☐	☐	☐
Tdap	9	Do you have a seizure disorder or a brain disorder?	☐	☐	☐
Live	10	Have you received any vaccination in the past 4 weeks? Which one(s)?	☐	☐	☐
	11	Do you have cancer, leukemia, HIV, active shingles or any other immune system problem?	☐	☐	☐
	12	Do you take prednisone, oral steroids, anticancer or antiviral drugs or medications that affect the immune system?	☐	☐	☐
	13	During the past year, have you received a transfusion of blood or blood products, been given a medicine called immune (gamma) globulin, or had radiation therapy?	☐	☐	☐

----------**BELOW LINE FOR PHARMACY USE ONLY**----------

Check Box to Confirm Patient Identity Verified ☐ Check Box to Confirm Vaccine / Drug to be administered Verified ☐

Vaccine	Lot# of Vaccine	Exp Date	Manufacturer	Dosage	Site of Injection	Time	VIS Date
Influenza (Seasonal)				0.5mL	IM L / R Deltoid		July 2014
Fluzone HD® (≥65 yrs)			Sanofi	0.5mL	IM L / R Deltoid		July 2014
Zostavax®			Merck	0.65mL	SC L / R PLUA		Oct 6, 2009
Pneumovax®			Merck	0.5mL	IM L / R Deltoid SC L / R PLUA		Oct 6, 2009
Tdap				0.5mL	IM L / R Deltoid SC L / R PLUA		May 9th 2013
					IM L / R Deltoid SC L / R PLUA		

Signature of Pharmacist: _____ **RPh** _____ **Intern Initials** **Date VIS provided to patient:** _____

Date / Time Faxed to MD _____ / _____ **AM / PM** **Counseling: Accepted** _____ **Declined** _____

Initials/Date/Time_____

15010

Race / Ethnicity
- ☐ White
- ☐ Black/African American
- ☐ Asian
- ☐ Hispanic or Latino
- ☐ Native American or Alaska Native
- ☐ Native Hawaiian or Pacific Islander
- ☐ Decline to State

Gender
- ☐ Male
- ☐ Female

Mother's Maiden Name: _____

Patient Health Questionnaire, Consent Form, and VAR

Section A Please Print Clearly

Last Name | First Name | MI | Date of Birth | Age

Medicare/Ins ID # | Rx Group # | Bin #

Home Address | City | State | ZIP | Phone #

Primary Care Physician | Physician Address | Physician Phone #

Are you covered by Medicaid? (circle): Yes No **Are you covered by Medicare Part B or D? (circle): Yes No**

Vaccine Requested (circle): Flu Pneumonia Shingles Tdap Td MMR Hep A Hep B HPV Meningococcal Varicella Other _____

Section B *The following question will help us determine your eligibility to be vaccinated today*	Yes	No
1. Is the person to be vaccinated feeling sick today or do they have a moderate to high fever? **RPH Initials: _____**		
2. Does the person to be vaccinated have allergies to medications, food, vaccine components or latex? (Examples: eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal)		
3. Has the person to be vaccinated received any vaccination or skin tests in the past four weeks? If yes, please list the vaccination:		
4. Has the person to be vaccinated ever had a serious reaction to an influenza vaccine or any other vaccine?		
5. Has the person to be vaccinated ever had a seizure disorder, brain disorder, or Guillain-Barre Syndrome?		
6. Is the person to be vaccinated pregnant or considering becoming pregnant in the next month?		
7. Is the person to be vaccinated 65 years of age or older?		
8. Is the person to be vaccinated a smoker?		
9. Does the person to be vaccinated have a chronic condition or long term health problem such as, heart disease, lung disease, asthma, kidney disease, diabetes, anemia, or other blood disorders?		
10. If a person answers YES to question # 7, 8, or 9, have you ever had a pneumonia vaccination?		
11. Has the person to be vaccinated ever had a shingles vaccination (patients 60 years of age and older)?		
12. Is the person to be vaccinated currently on home infusions, weekly injections, steroid therapy, anticancer drugs or radiation treatment?		
13. Does the person to be vaccinated have cancer, leukemia, lymphoma, HIV/AIDS or any other immune system disorder or are you in contact with anyone who has a severely weakened immune system?		
14. Has the person to be vaccinated received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug during the past year?		

IF A PERSON ANSWERS YES TO ANY QUESTION, THEY MUST TALK TO PHARMACIST BEFORE BEING VACCINATED

Section C Consent and Waiver: *Please read each section carefully and initial in the corresponding box acknowledging that you understand and agree.*

I hereby give my consent to Walmart, as applicable, to administer the medications(s) I have requested above. I understand the benefits and risks of receiving this medication and have received, read and/or had explained to me the Vaccine Information Statement on the vaccine(s) I have elected to receive. I acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. I acknowledge that I have been advised to remain near the vaccination location for approximately 20 minutes after administration for observation by the administering healthcare provider. On behalf of myself, my heirs, and personal representatives, I fully release and discharge Walmart , its staff, agents, successor, division, affiliates, officers, directors, contractors, and employees from any and all liabilities or claims whether known or unknown arising in any way related to the administration of the vaccine(s) listed above.

Initials _____

I understand the purposes/benefits of my state's immunization registry and acknowledge that, depending upon my state law, I may prevent disclosure of my immunization to the state registry with a signed Opt-Out.

Initials _____

I assign payment of authorized insurance benefits due to me to be paid to the pharmacy. I consent to the release of medical information when necessary for billing, reimbursement, and medical protocol.

Initials _____

I am aware an immunization certified student pharmacist might be administering this medication.

Initials _____

Patient Signature/Legal Guardian: _____ **Date:** _____

Section D *The following section is to be completed by* ***health care provider only.***

Immunizing Pharmacist Name (Print) _____ **Immunizing Pharmacist Signature** _____

Intern Name (Print) _____ **Administration Date/Date VIS Given:** _____

Vaccine	Lot#	Exp. Date	Manufacturer	NDC	Dosage	Site (LA/RA)	Route (IM/SQ)	VIS Date	RPh Initials
						LA RA	IM / SQ		
						LA RA	IM / SQ		
						LA RA	IM / SQ		
						LN RN	Nasal		

Authorizing Physician: Address of Authorizing Physician:

Phone : Fax :