SPARTA PHARMACY

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Patient Name:_____ Date of Birth: ___/___/____ (mm) (dd) (yr)

Phone Number:_____ Age_____

Address: _____ City, State, Zip _____

Patient Social Security Number or Medicare Number : _____

Insurance_____RX Bin#_____RX PCN# _____RX GROUP#_____ID#_____

Consent for Administration of the following Vaccines:

___Influenza (Flu) ___Hepatitis A ___Hepatitis B
___Meningococcal ___Tetanus, Diptheria, Pertussis ___Pneumococcal
___Herpes Zoster (Shingles) ___Measules, Mumps, Rubella ___Human Papillomavirus

SCREENING QUESTIONNAIRE FOR IMMUNIZATION

(For Flu Vaccine fill out questions 1-4 only)

For adult patients to be vaccinated: 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 healthcare provider to explain it.

1. Is the person to be vaccinated sick today? ☐ YES ☐ NO
2. Does the person to be vaccinated have any allergies to medications, food, a vaccine component, or latex? ☐ YES ☐ NO
3. Has the person to be vaccinated ever had a serious reaction after receiving a vaccination in the past? ☐ YES ☐ NO
4. Has the person to be vaccinated ever had Guillain-Barré syndrome? ☐ YES ☐ NO
5. Does the person have any long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder? ☐ YES ☐ NO
6. Does the person have cancer, leukemia, AIDS, or any other immune system problem? ☐ YES ☐ NO
7. Does the person take cortisone, prednisone, other steroids, or anti-cancer drugs, or have you had radiation treatments? ☐ YES ☐ NO
8. Has the person had a seizure or a brain or other nervous system problem? ☐ YES ☐ NO
9. During the past year, has the person received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? ☐ YES ☐ NO
10. For women: Is the person pregnant or is there a chance she could become pregnant during the next month? ☐ YES ☐ NO
11. Has the person received any vaccinations in the past 4 weeks? ☐ YES ☐ NO

Patient Signature : _____ Date: _____

(Parent or guardian, if patient is under 18 years of age)

TO BE COMPLETED BY PHARMACIST

Date	Vaccine	Manufacturer	Lot#	Expiration	Dose	Site	VIS Date
					0.5ML	☐ RIGHT ARM ☐ LEFT ARM	
					0.5ML	☐ RIGHT ARM ☐ LEFT ARM	
					0.5ML	☐ RIGHT ARM ☐ LEFT ARM	

Name of administrator of vaccine: _____ Signature: _____