SPARTA PHARMACY

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Hours: Mon-Fri 9am-8pm | Sat 9am-5pm | Sun 9am-2pm

UNIVERSAL VACCINE SCREENING & CONSENT FORM

A PATIENT INFORMATION

Please complete this form before your vaccination appointment. Bring your insurance card and photo ID.

First Name: _____ Last Name: _____

Date of Birth: _____ Age: _____ Gender: ☐ M ☐ F ☐ Other

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

Phone: _____ Email: _____

Last 4 SSN or Medicare ID# (for eligibility lookup): _____ Preferred Arm: ☐ Left ☐ Right

Insurance: _____ ID#: _____ Group: _____ BIN: _____ PCN: _____

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other ☐ Unknown

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

B WHICH VACCINE(S) ARE YOU HERE FOR TODAY? (Check all that apply)

☐ Influenza (Flucelvax / Fluad 65+)
☐ COVID-19 (Pfizer / Moderna)
☐ RSV (mRESVIA / ABRYSVO)
☐ Shingles (Shingrix)
☐ Pneumococcal (Prevnar20 / Capvaxive)
☐ Tdap (Boostrix)
☐ Hepatitis A (Havrix)
☐ Hepatitis B (Engerix-B)
☐ Meningococcal (Menquadfi / Penbraya)
☐ MMR (M-M-R II)
☐ HPV (Gardasil 9)
☐ Other: _____

C HEALTH SCREENING

Check ALL that apply to you. Leave blank if none apply.

☐ I am feeling sick today
☐ I have had a serious reaction after receiving a vaccine
☐ I have a history of Guillain-Barré Syndrome
☐ I have allergies to medications, food, vaccine components, or latex
☐ I have felt dizzy or fainted before, during, or after a shot
☐ I am anxious about getting a shot today

FLU ONLY? Skip questions below. • ALL OTHER VACCINES — Continue below:

☐ I have long-term health problems (heart, lung, kidney, liver, diabetes, asthma, blood disorder)
☐ I have cancer, leukemia, HIV/AIDS, or an immune system problem
☐ I have had a seizure or brain/nervous system problem
☐ I am pregnant or may become pregnant in the next month
☐ I have a bleeding disorder or take blood thinners
☐ I have taken immunosuppressive meds in the past 6 months (steroids, anticancer drugs, radiation)
☐ I have been diagnosed with myocarditis, pericarditis, or MIS-C after COVID-19
☐ I received blood products, immune globulin, or antiviral drugs in the past year
☐ I have received a vaccination in the past 4 weeks
☐ Other / Questions: _____

☐ **None of the above apply to me**

D VACCINE ADMINISTRATION RECORD (Pharmacy Use Only)

VACCINE 1	VACCINE 2	VACCINE 3
Place sticker here	Place sticker here	Place sticker here
Vaccine:	Vaccine:	Vaccine:
Mfg:	Mfg:	Mfg:
Lot#:	Lot#:	Lot#:
Exp:	Exp:	Exp:
VIS Date:	VIS Date:	VIS Date:
Site: ☐ L Arm ☐ R Arm ☐ _____	Site: ☐ L Arm ☐ R Arm ☐ _____	Site: ☐ L Arm ☐ R Arm ☐ _____
Administered: RPh/Tech/Nurse	Administered: RPh/Tech/Nurse	Administered: RPh/Tech/Nurse

E CONSENT & AUTHORIZATION

ONLY if patient is under 18 — please PRINT below:

Parent/Guardian Name/DOB: _____ Relationship: _____ PCP Name: _____

I have reviewed the information provided, had a chance to ask questions, and consent to receive the vaccine(s) selected above. I understand the benefits and risks of vaccination. I authorize Sparta Pharmacy to administer/bill my insurance for the immunization services provided. I will remain in the pharmacy for at least 15 minutes after vaccination for observation.

Patient / Guardian Signature _____ Date _____ Form Reviewed by: RPh / Tech / Nurse (circle one) _____ Date _____