IMMUNIZATION SCREENING AND CONSENT FORM

NAME:	**Which Vaccine(s) Would You Like Today? In Which Arm?**			
	☐ **Moderna** (5+)	Left - Right	☐ **Flu** (3+)	Left - Right
DOB:	☐ **Pfizer** (12+)	Left - Right	☐ **Shingles** (50+)	Left - Right
	☐ **Novavax** (12+)	Left - Right	☐ **Pneumococcal** (18+)	Left - Right
IF YOU ARE NEW TO US PLEASE COMPLETE FIELDS BELOW::	☐ **RSV** (60+)	Left - Right	☐ **Tetanus/Pertussis** (18+)	Left - Right
STREET ADDRESS + ZIP CODE:	☐ **MMR** (18+)	Left - Right		
	☐	Left - Right		
PHONE				

STAFF NOTES:	**VIS DATES**	COVID-19 01-31-25	PCV 05-29-25	Tdap 01-31-25
		Flu 01-31-25	RSV 01-31-25	
		MMR 01-31-25	Shingles 02-04-22	

Pre-Immunization Questionnaire

1. Are you sick today? Do you have symptoms other than mild coughing, runny nose, and/or diarrhea?	☐ Yes ☐ No
2. Do you have allergies to food (GELATIN, EGGS?), medication, or vaccines? If yes, please list:	☐ Yes ☐ No
3. Have you ever had a serious reaction after receiving influenza, pneumonia, or any other vaccination?	☐ Yes ☐ No
4. Are you being vaccinated against COVID-19 today?	☐ Yes ☐ No

<u>If yes</u>, <u>complete the following</u>**:**

→ What was the ***approximate*** last date of vaccination against COVID-19? _____

→ What COVID-19 vaccine was used for your most recent dose?

☐ Moderna ☐ Pfizer ☐ Novavax ☐ Other: _____

→ Check all that apply to the person being vaccinated against COVID-19:

☐ Have a history of myocarditis or pericarditis
☐ Have a history of thrombosis with thrombocytopenia syndrome (TTS)
☐ Have a history of Guillain-Barré Syndrome (GBS)
☐ Vaccinated with monkeypox vaccine in the last 4 weeks?
☐ Have a history of Multisystem Inflammatory Syndrome (MIS-C or MIS-A)?
☐ History of an immune-mediated syndrome defined by thrombosis and thrombocytopenia, such as heparin- induced thrombocytopenia (HIT)
☐ Have a history of COVID-19 w/in the past 3 mos?

→ **<u>If under 65 years old</u>,** Check all that apply to the person being vaccinated against COVID-19:

☐ **Heart disease** (coronary artery disease, heart failure)
☐ **Cerebrovascular disease** (stroke)
☐ **Lung disease** (COPD, asthma, pulmonary fibrosis, CF)
☐ **Diabetes** (Type 1, Type 2 or gestational)
☐ **Kidney disease** (especially chronic kidney disease, dialysis)
☐ **Liver disease** (e.g., cirrhosis, hepatitis, fatty liver)
☐ **Neurologic conditions** (stroke, dementia, spinal cord injuries)
☐ **Caregivers, household contacts of high risk persons**
☐ **Obesity/Overweight** (BMI ≥25)
☐ **Physical inactivity**
☐ **Smoking** (current or former smokers)
☐ **Pregnancy** (current or recent)
☐ **Children under 5 years** (for certain vaccines)
☐ **Residents of long-term care facilities**
☐ **Mental health conditions** (depression, anxiety, schizophrenia)
☐ **Healthcare/Congregate care worker**
☐ **Disabilities** (e.g., Down syndrome, other developmental disabilities)
☐ **Cancer** (especially if undergoing treatment)
☐ **HIV/AIDS**
☐ **Organ transplant recipients**
☐ **On immunosuppressive therapy** (e.g., chemotherapy, biologics, corticosteroids)

OTHER:

Immunization Agreement

- I have received the Vaccine Information Statement (VIS).
- I will remain in the pharmacy after the injection for observation and will notify Village Apothecary of any adverse events associated with immunization.
- Permission is hereby granted to the Village Apothecary to release information to my primary physician regarding vaccinations received today.
- I hereby release Village Apothecary, pharmacists, staff, sponsoring physician, and their respective affiliates, contractors, agents, and employees, from any and all claims arising out of, in connection with or in any way related to my receipt of this/these immunization(s). Village Apothecary and aforementioned parties shall not at any time or to any extent whatsoever be liable, responsible, or in 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.
- I understand Village Apothecary will submit all immunizations for all patients to the New York State Immunization Information System (NYSIIS).

I have been counseled and believe the benefits outweigh the risks and agree to be vaccinated today with the above selected vaccines

Signature	**Printed Name** ☐ **I am the patient's parent or guardian**	**Date**

☐ **I DO NOT have a Primary Care Physician**
☐ **I DO have a Primary Care Physician** **Physician Name**:_____

Immunizer Signature	**Printed Name**	**Title**	**Date**	**Address of Vaccination**
	☐ Neal Smoller ☐ Nicole Ball ☐ Kayla Costello	☐ RPh ☐ RN ☐ LPN		☐ 79 Tinker Street, Woodstock, NY 12498 ☐