FAMILY PHARMACY
CUMBERLAND | FARMVILLE | AMELIA

Please have your insurance card available, including Medicare card if applicable.

VACCINE SCREENING FORM

NAME: _____ **DOB:**_____ **AGE:**_____

ADDRESS: _____

PHONE #: _____ **EMAIL:** _____

RACE: _____ **GENDER ASSIGNED AT BIRTH:** **M** **F**

Circle the vaccine(s) you are receiving today:

Influenza **Covid** **Pneumonia** **RSV** **Shingles** **Tdap** **Meningitis** **HepB** **HPV**

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 we need to ask you more questions. If a question is not clear, please ask your healthcare provider to explain it.

	YES	N0	DON'T KNOW
Are you sick today?			
Do you have allergies to medications, food, latex, or any vaccines?			
Have you ever had a serious reaction or fainted after receiving a vaccine?			
Do you currently smoke?			
Do you have a long-term healthcare condition such as asthma, COPD, diabetes, heart disease, hypertension, kidney disease, liver disease, are immunosuppressed, or other condition?			
Have you had a seizure or a brain or other nervous system problem, including Guillain-Barre' Syndrome (GBS)?			
For women: Are you pregnant?			
If 50 or older: Have you ever had a Shingles Vaccination?			
If 60 or older: Have you had the RSV vaccine?			
If over the age of 65: Have you ever had a pneumococcal vaccine?			
For Covid Vaccine: Has it been at least two (2) months since your last dose of Covid vaccine?			
For Covid Vaccine: Do you have a history of myocarditis or pericarditis?			
For Covid Vaccine: Do you have a history of Multisystem Inflammatory Syndrome (MIS-C or MIS-A)?			
For Covid Vaccine: Have you been diagnosed with Covid-19 disease within the past 3 months, or still experiencing symptoms?			

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 the risks of the vaccine(s) being administered and have received a copy of the current VIS. I request that the vaccine(s) be administered to me or to the person named above for whom I am authorized to make this request. If, for some reason, my insurance plan does not cover the cost and/or administration of the vaccine by a pharmacist, I understand I will be responsible for the cost of the vaccine and the administration.

Signature of patient, guardian, or POA: _____

Relationship to patient: _____

Date: _____

Insurance Information:

*Please complete this section if you are receiving a vaccine at an off-site clinic or you do not have your insurance information with you.

Name as it appears on you Insurance card and/or Medicare card:

_____

Member ID: _____ Rx Group:_____

Rx Bin: _____ Rx PCN:_____

Medicare Beneficiary ID: _____

SS# (If no other information is available): _____

For Internal Use:

VACCINE NAME/MANUFACTURER	LOT NUMBER	EXPIRATION DATE	DOSE	INJECTION SITE	ACCES TO/OR CURRENT VIS GIVEN?

Vaccine administered by: _____

Supervising Pharmacist: _____
(If administered by a technician)

Date Administered: _____

Clinic Site:_____
(For offsite clinics)