Updated 8/17/2020

Vaccination Screening & Consent

Eligible for use with live vaccines such as MMR, Varicella, Zostavax, FluMist, or Oral Typhoid

Name: _____ DoB: _____ Phone: _____

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

Allergies: _____ Insurance *BIN:* _____ *PCN:* _____ *Group:* _____ *ID:* _____

Primary Care Provider: _____ Phone: _____ Fax: _____

[ ] I **DO NOT** have a primary care provider or am unable to provide their contact information

Screening Questions *If a question is not clear, please ask the pharmacist to explain it.*		**Yes**	**No**	**Don't Know**
Health Screening	1. Are you sick today?			
	2. Have you had any COVID-19 symptoms in the past 14 days including: • Cough • Fever >100.4°F • Unexpected shortness of breath • Muscle or body aches • Chills • Sore throat • New loss of taste or smell • Fatigue • Headache • Congestion or runny nose • Nausea or vomiting • Diarrhea ***(circle all that apply)***			
	3. Have you had, or have you been in contact with anyone with, confirmed or suspected Coronavirus (COVID-19) infection within the past 14 days?			
****STOP:** If you answered yes to any of the above questions, speak with the pharmacist before completing this form**				
Vaccine History	4. Do you Smoke?			
	5. Do you have Asthma, Diabetes, or Heart Disease?			
	6. Have you ever had a Pneumonia vaccine? If so, When? _____			
	7. Have you ever had a Shingles vaccine? If so, When? _____			
	8. When was your most recent Tetanus shot? _____			
All Vaccines	9. Do you have a serious allergy to any vaccine component? (Examples: Eggs, Gelatin, Thimerosal, Neomycin, Gentamicin, Latex) *If Yes, please list:* _____			
	10. Have you ever had a serious reaction or fainted after receiving any vaccination?			
	11. Do you have a seizure or brain disorder or other nervous system problem?			
Women	12. Are you pregnant, or are you considering becoming pregnant in the next month?			
Live Vaccines Only	13. Have you received any other vaccines in the past 4 weeks? *If Yes, please list:* _____			
	14. Do you have cancer, leukemia, HIV/AIDS, active shingles, or any other immune system problem?			
	15. Do you have a parent, brother, or sister with an immune system problem?			
	16. In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?			
	17. During the past year, have you received a transfusion of blood or blood products, or been given medicine called immune (gamma) globulin or an antiviral drug?			

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 Save Mart/Lucky Supermarkets on behalf of its Pharmacy operations in all divisions 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 Save Mart/Lucky, 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 Save Mart/Lucky 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 Save Mart/Lucky 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 Save Mart/Lucky 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 Save Mart/Lucky 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 / Parent or Guardian of Minor	Date	Print name of Parent or Guardian and Phone Number

******************************Below Line For Pharmacist Use Only******************************

Vaccine	Lot #	Exp Date	Mfr	Dosage	Injection Site	Time	Date on VIS
Pharmacist Signature:					Date VIS provided to patient:		