Pharmacy Use Only
In Store Vaccination Yes ___ No ___
Wellness Clinic Yes ___ No ___
Location/Employer _____

Health Mart PHARMACY
Caring for you and about you

Screening Questionnaire and Consent Form

Patient Information:(To be completed by patient--please print clearly)

Patient Name: _____
Date of Birth: ___/___/____ Age_____
Home Phone#_____ Mobile#_____
Street Address:_____
City:_____ State:____ Zip:_____
County:_____
Gender: Male or Female (Circle one)
E-mail Address: _____
Mother's First Name: _____
Mother's Maiden Name: _____
Allergies:_____

Current Weight_____ Medical Conditions:_____
Emergency Contact Name & Phone Number:_____
Ethnicity (Circle one): Hispanic or Latino Not Hispanic or Latino
Race (Circle one): American Indian Alaska Native Asian
Black or African American Native Hawaiian/Pacific Islander
White Other
Primary Physician Name:_____
Physician Address: _____
Physician Phone Number:_____

Desired Injection Site Location (Circle one): RT Arm LT Arm

I would like to receive the following **immunization(s):** _____

Please answer the following questions. Your answers will help us determine which vaccines we may give you today. If there are any questions you do not understand, our pharmacist will be happy to go over it with you.

Please note: If you answer any of these questions "yes", it does not mean you should not be vaccinated. It just means additional questions must be asked. Our pharmacist will determine which vaccines you may receive based on your particular situation.	**Yes**	**No**	**Don't Know Ask Our Pharmacist?**
1. Are you sick today?			
2. Do you have any allergies to food (Ex. Eggs), vaccine component (Ex. neomycin, formaldehyde, gentamicin, thimerosal, bovine protein, phenol, polymyxin, gelatin, baker's yeast or yeast)? Do you have any allergies to **Latex**?			
3. Have you had any serious reactions after receiving a vaccination including fainting or feeling dizzy?			
4. Do you have any long-term health problems such as heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g. diabetes), anemia, or other blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Are you on long-term aspirin therapy?			
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune problem?			
6. Do you have a parent, brother, or sister with an immune system problem?			
7. In the past 3 months, have you taken any medications that weaken your immune system, such as cortisone, prednisone, other steroids, Humira (adalimumab), Remicade (infliximab), Embrel (etanercept), methotrexate, azathioprine, 6-mercaptopurine, antivirals or anticancer drugs, drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis, or have you had radiation treatments?			
8. Do you have any neurological disorders such as seizures, or others disorders that affect the brain?			
9. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?			
10. For women: Are you pregnant or is there a chance you could become pregnant during the next month?			
11. Have you received any vaccinations in the past 4 weeks?			
12. Do you smoke?			
13. Are you taking antibiotics or antimalarial medications?			
14. Have you ever tested positive for **COVID-19**? If Yes, please provide the date:_____			
Did you bring your immunization record card with you? ** It is important for you to have a personal record of your vaccinations. If you don't have a personal record, we will provide you one today. Keep this record in a safe place and bring it with you every time you seek medical care.			

Questionnaire completed by_____ **Date** ___/___/____ **Questionnaire reviewed by**_____ **Date**___/___/____

CONSENT FORM

I Certify that:

- I am (a): the patient and at least 18 years of age; (b) the parent or legal guardian of the patient.
- I authorize the healthcare provider of Larchmont Pharmacy LLC to administer the vaccine(s) requested by me above.
- I have read and understand the Vaccination Information Sheet (VIS) regarding the vaccine(s). I understand the benefits and risks of the vaccine(s). I have had the opportunity to ask questions and that such questions have been answered to my satisfaction. I hereby release and hold harmless Larchmont Pharmacy LLC, its affiliates, subsidiaries, officers, directors, contractors, and employees from any and all liabilities or claims whether know or unknown arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above.
- I acknowledge that the pharmacist recommends that patients remain in the waiting area, for 15 minutes, after the administration of the immunization.
- I understand that my vaccination record may be shared with federal, state, and city agencies for registry report purposes or other purposes as required by law.
- I have received a copy of Larchmont Pharmacy's Notice of Privacy Practices for Protected Health Information.
- I authorize the pharmacist to release any vaccine documents to my primary care provider or any of my health care providers.
- I authorize the release of any medical or other information with respect to this/ these vaccines to my health care providers, Medicare, Medicaid, or any other third party payer as needed and request payment of all authorized benefits to be made to Larchmont Pharmacy LLC
- I understand that I am fully responsible for any cost sharing amounts, including copays, coinsurance, and deductibles for the requested items and services as well as any items or services that are not covered by my insurance benefits. Any payments for which I am financially responsible are due at the time of the service. If Larchmont Pharmacy's chooses to invoice me, than the payment is due upon receipt of the invoice.
- I understand that receiving this immunization is not a substitute for receiving an annual check-up with my primary care physician.

Patient or Legal Guardian of Patient Signature_____

Patient of Legal Guardian of Patient Printed Name_____

HEALTHCARE PROVIDER USE ONLY

PLEASE CIRCLE ALL THAT APPLY:

Dtap	**HPV**	**MMR**	**Td**
HepA	**Influenza Injectable**	**Pneumococcal**	**Tdap**
HepB	**Meningococcal**	**Shingrix**	**Varicella**

PLACE RX LABEL HERE	**PLACE RX LABEL HERE**

IMMUNIZER CHECK LIST

Preparing for Vaccine Administration:

Review the patient information and screening questions Initials _____

Determine the vaccine(s) desired by the patient Initials _____

Determine the appropriateness of the vaccine(s) for the patient based on Age, State & Federal regulations and company policies. Initials ____

Does the patient have a High Risk Medical Conditions Initials _____

List Medical conditions_____

The Vaccine NDC Matches the NDC on this VAR form Initials _____

Check the Expiration Date, verify the date is greater than today's and enter the Lot # and Expiration Date in the fields below. Initials _____

During Vaccine Administration:

Confirm patient Name, Date of Birth, and Requested Vaccine Initials _____

Review Screening Questions with Patient Initials _____

Review VIS with Patient Initials _____

Reported to NYSIIS—Yes/No Initials _____

Reported to Primary Care Physician (PCP)—Yes/No Initials _____

After Vaccine Administration:

VACCINE	NDC NUMBER	MANUFACTURER	LOT NUMBER	EXPIRATION DATE	DOSAGE	SITE ADMIN	VIS Date Given	Funding Source (C,I,M)

Immunizer Name (Print):_____

If applicable, Intern Name (Print): _____

Title: _____

Administration Date: _____

Immunizer who provided administration of vaccine(s) and VIS to patient

Signature: _____

License Number: _____