Health Mart PHARMACY

University Commons Pharmacy
Your health is our priority!

Patient Information

First Name: Last Name : Gender **M F** Date of birth / /

Phone #: St. Address: City: State: Zip:

Weight If less than 110 lbs: PCP Name: PCP Phone

Social Security #: Medicare ID #

Check vaccine requested: Flu ____ Pneumonia ____ COVID ____ RSV ____ Shingles ____ Tdap ____
Other (Please Specify) ________________

Screening Questions	Yes	No	Don't Know
1. Are you sick today?			
2. Do you have allergies to medications, food, a vaccine component, or latex?			
3. Have you ever had a serious reaction after receiving a vaccine?			
4. Do you have any of the following: a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, 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 system problem?			
6. Do you have a parent, brother, or sister with an immune system problem?			
7. In the past 6 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?			
8. Have you had a seizure or a brain or other nervous system problem?			
9. Have you ever been diagnosed with a heart condition (myocarditis or pericarditis)or have you had Multisystem Inflammatory Syndrome (MIS-A or MIS-C) after an infection with the virus that causes COVID-19?			
10. In the past year, have you received immune (gamma) globulin, blood/blood products, or antiviral drug?			
11. Are you pregnant?			
12. Have you received any vaccinations in the past 4 weeks?			
13. Have you ever felt dizzy or faint before, during, or after a shot?			
14. Are you anxious about getting a shot today?			

- I authorize the Pharmacy to submit a claim to my insurer for the above requested service(s) and request payment of authorized benefits be made on my behalf to the Pharmacy.
- I fully understand that I will ultimately be responsible for any charges if I am not a covered person under the insurance plan I provided, the services are not covered services, or for any co-pays, deductibles or coinsurance obligations that apply.
- I certify that I am the patient and at least 18 years of age; the legal guardian of the patient; or a person authorized to consent on behalf of the patient where the patient is not otherwise competent or unable to consent for themselves.
- I have been provided the Vaccine Information Statement or Emergency Use Authorization Fact Sheet for Recipients & Caregivers for the vaccine(s) to be administered and understand the risks and benefits.
- I GIVE CONSENT to the pharmacy and its staff for myself, or the person listed above to be vaccinated with the vaccine(s) requested above.

I hereby certify that the above information is true and correct to the best of my knowledge and I agree to the terms and conditions stated above.

Signature : Date: / /

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The following is to be completed by the health care provider ONLY.

Vaccine Name	Lot #	Exp Date	Manufacturer	NDC	Site	Route	Amin Date

Lot # Exp Date: Amin Date: / / Site: Route	Lot # Exp Date: Amin Date: / / Site: Route	Lot # Exp Date: Amin Date: / / Site: Route	Lot # Exp Date: Amin Date: / / Site: Route

Ordering R.Ph. name	Signnature	VIS Date.	Date