Immunization Screening/Consent Form (VAR FOR INDIVIDUAL USE)

*Patient Name: _____*Date of Birth: _____ *Age: _____ *Phone# _____

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

*Primary Care Physician (PCP):_____ *Dr. Phone number: _____

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

FOR COVID VACCINES ONLY-For those under 65 years of age, I certify that I have a chronic Condition such as those listed on the back of this form. Please initial to the right ------→	**INITIAL**		
The following questions will help us determine which vaccines may be given today. If a question is not clear, please ask the pharmacist.	**Yes**	**No**	**Don't Know**
Are you **sick today**?			
Do you have a long-term health problem with heart disease, kidney disease, metabolic disorder (e.g., diabetes), anemia or other blood disorders?			
Do you have a long-term health problem with lung disease or asthma? Do you smoke?			
Do you have allergies to medications, food (e.g., eggs), latex or any vaccine component (e.g., neomycin, formaldehyde, gentamicin, thimerosal, bovine protein, phenol, polymyxin, gelatin, chicken or yeast?			
Have you received any vaccinations in the past 2 weeks?			
Have you ever had a **serious reaction** after receiving a vaccination?			
Do you have a neurological disorder such as seizures or other disorders that affect the brain or have had a disorder that resulted from a vaccine (e.g., Guillain-Barre Syndrome)?			
Do you have **cancer, leukemia, AIDS,** or any other immune system problem?			
Do you take prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?			
During the past year, have you received a transfusion of blood or blood products, including antibodies?			
For women: Are you pregnant or could you become pregnant in the next three months?			

* I am aware the pharmacist will send copies of my vaccine documents to my primary care provider **Yes ___ No ___**

*I have read, or have had explained to me, the information contained in the Vaccine Information Statement(s) regarding the vaccine(s) to be administered today. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the specific vaccine(s) and I ask that the vaccine(s) be given to me, or to the person for whom I am authorized to make this request. I also authorize Stark Pharmacy to release my immunization information record, or the immunization record of the person for whom I am authorized to make this request, to appropriate personnel or other health care provider(s) as needed. **Please stay in pharmacy 10-15 min post vaccination for observation.**

Vaccine Recipient Signature X **Date**

(Pharmacy Use Only Below)

1. Covid Lot # _____ Exp. Date: _____ Manufacturer: _____	**4. Tdap** Lot # _____ Exp. Date: _____ Manufacturer: _____ VIS: 02/24/15
2. Influenza Lot # _____ Exp. Date: _____ Manufacturer: _____ VIS: 09/15/19	**5. Zoster (Shingles)** Lot # _____ Exp. Date: _____ Manufacturer: _____ VIS: 10/30/19
3. Pneumococcal Lot # _____ Exp. Date: _____ Manufacturer: _____ VIS 10/30/19 for both	**6. Other** **VIS Date** Lot # _____ Exp. Date: _____ Manufacturer: _____
Injection#_____ Dosage: _____ Site: IM/Sub-q **R or L** Delt**.** (Circle one)	**Injection#_____ Dosage: _____** Site: IM/Sub-q **R or L** Delt**.** (Circle one)

Authorizing Physician: Douglas Cochran, MD 4320 Wornall Rd Kansas City, MO 64111 Phone: 816-932-6100/ Fax: 816-932-9002 DEA#: BC2182614 NPI#:1144229261 RPH Precheck Initials above	Pharmacist who administered vaccine(s) to patient: Signature **X**

Required Covid Vaccine Chronic Diseases

Asthma

Blood cancers

Cerebrovascular diseases

Chronic kidney disease

Some chronic lung diseases

Some chronic liver diseases

Cystic fibrosis

Type 1 and 2 diabetes

Gestational diabetes

Disabilities, including Down syndrome

Heart conditions

HIV

Mood disorders, including depression and schizophrenia

Dementia

Parkinson's disease

Obesity

Physical inactivity

Current or recent pregnancy

Primary immunodeficiencies

Current or former smoking

Solid organ or blood stem cell transplant recipients

Tuberculosis

Use of immunosuppressive drugs