SMITH PHARMACY (920)788-8888 Little Chute, WI est. 2013

Vaccination Screening Questionnaire

_____
First Name Last Name

_____
Home Address

_____ _____
City State ZIP Phone Number

Pharmacy vaccinations limited to 6 years old +

_____ / _____ / _____
Date of Birth (MM/DD/YY)

1800 Freedom Road Little Chute, WI 54140
920-788-8888

Flu	RSV	Pneumonia	Shingles	Tdap	COVID-19	MMR	Hep A	Hep B	Meningococcal

		YES	NO
1.	Do you have symptoms of cold, flu, COVID-19, or any other illness now? *[all vaccines]*		
2.	Do you have allergies to medications (neomycin) food (eggs/gelatin), vaccine components, or latex? *[all vaccines]* Do you have any allergies to any components of the SARS-CoV-2 vaccine, PEG, or polysorbate? *[COVID-19]*		
3.	Have you ever had a serious reaction after receiving a vaccination? *[all vaccines]*		
4.	Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem? *[LAIV, MMR]*		
5.	In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease or psoriasis; or had chemotherapy or radiation treatments? *[LAIV, MMR, VAR]*		
6.	Have you had a seizure or other nervous system issues- such as Guillain-Barre Syndrome? *[Flu, Tdap]*		
7.	During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? *[LAIV, MMR, VAR]*		
8.	Are you 65 years of age or older?		
9.	**For women:** Are you currently pregnant or breastfeeding, or is there a chance you could become pregnant during the next month? *[MMR, LAIV, VAR, ZOS]*		

I have read, or have had explained to me, the information regarding the vaccine(s) marked above. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) being administered and authorize the administration of the vaccine to me or the person named above for whom I am authorized to make the decision. I, for myself, my heirs, and executors release Smith Pharmacy, Change Healthcare as the Medicare provider, any retail or external site, physician, and employees, from any and all claims arising out of, or in any way related to my receipt of this or these immunization(s). Smith Pharmacy and the aforementioned related parties shall not at any time or any extent be liable or responsible for any loss, injury, death, or damage to be suffered or sustained at any time as a result of this vaccination program. I agree to wait in the vaccination location for approximately 20 minutes for observation after vaccination.

I authorize Smith Pharmacy, and Change Healthcare to release information and request payment. I certify that the information given by me in applying for payment under Medicare is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf to Change Healthcare as my Medicare Part B provider.

Patient Signature: _____ Date: _____

For patients between 14-17 years old, both the patient **AND** legal guardian must sign consent.

Legal Guardian/Power of Attorney Signature: _____ Date: _____

_ _ _ _ _ _ {*section below this line is to be filled out by pharmacy staff*} _

Vaccine	Lot #	Exp. Date	Manuf.	LA/RA

Immunizer Signature:_____ Administration Date:_____

Information about the Screening Checklist for Contraindications to Vaccines

1. **Do you have symptoms of cold, flu, COVID-19, or any other illness now?** *[all vaccines]*
   There is no evidence that acute illness reduces vaccine efficacy or increases vaccine adverse events. However, as a precaution with moderate or severe acute illness, all vaccines should be delayed until the illness has improved. Mild illness (such as upper respiratory infections or diarrhea) are NOT contraindications to vaccination. Do not withhold vaccination if a person is taking antibiotics.

2. **Do you have allergies to medications, food, a vaccine component, or latex?** *[all vaccines]*
   An anaphylactic reaction to latex is a contraindication to vaccines that contain latex as a component or as part of the packaging. If a person has anaphylaxis after eating gelatin, do not administer vaccines containing gelatin. A local reaction to a prior vaccine dose or vaccine component, including latex, is not a contraindication to a subsequent dose or vaccine containing that component. An egg-free recombinant influenza vaccine (RIV3) may be used in people aged 18 and older with egg allergy of any severity who have no other contraindications. People younger than 18 years who have experienced a serious systemic or anaphylactic reaction after eating eggs can usually be vaccinated with inactivated influenza vaccine (IIV).

3. **Have you ever had a serious reaction after receiving a vaccination?** *[all vaccines]*
   History of anaphylactic reaction to a previous dose of vaccine or vaccine component is a contraindication for subsequent doses. Under normal circumstances, vaccines are deferred when a precaution is present. However, situations may arise when the benefit outweighs the risk.

4. **Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?** *[LAIV, MMR, VAR, ZOS]*
   Live virus vaccines are usually contraindicated in immunocompromised people. However, there are exceptions. For example, MMR vaccine is recommended and varicella vaccine should be considered for adults with CD4+ T-lymphocyte counts of greater than or equal to 200 cells/uL. Immunosuppressed people should not receive LAIV.

5. **In the past 3 months, have you taken medications that affect your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had chemotherapy or radiation treatments?** *[LAIV, MMR, VAR, ZOS]*
   Live virus vaccines should be postponed until after chemotherapy or long-term high-dose steroid therapy has ended. Some immune mediator and immune modulator drugs (adalimumab, infliximab, and etanercept) may be immunosuppressive. The use of live vaccines should be avoided in persons taking these drugs. LAIV can be given only to healthy non-pregnant people ages 2 through 49 years.

6. **Have you had a seizure or a brain or other nervous system problem?** *[Influenza, Td/Tdap]*
   Tdap is contraindicated in people who have a history of encephalopathy within 7 days following DTP/DTaP given before age 7 years. An unstable progressive neurologic problem is a precaution to the use of Tdap. For people with stable neurologic disorders (including seizures) unrelated to vaccination, or for people with a family history of seizures, vaccinate as usual. A history of Guillain- Barre syndrome is a consideration with the following. Td/Tdap: if GBS has occurred within 6 weeks of a tetanus-containing vaccine and decision is made to continue vaccination, give Tdap instead of TD if no history of prior Tdap. Influenza vaccine (IIV/LAIV): if GBS has occurred within 6 weeks of a prior influenza vaccine, vaccinate with IIV if at increased risk for severe influenza complications.

7. **During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?** *[LAIV, MMR, VAR, ZOS]*
   Certain live virus vaccines may need to be deferred, depending on several variables. Consult the most current AICP recommendations for current information on intervals between antiviral drugs, immune globulin or blood product administration and live virus vaccines.

8. **Are you 65 years of age or older?**
   Annual influenza vaccines are dosed based on age. Fluzone Quadrivalent vaccine is approved for use in individuals 6 months of age and older. Fluzone High-Dose Quadrivalent is approved for use in individuals 65 years of age or older.

9. **For women: Are you pregnant or is there a chance you could become pregnant during the next month?** *[MMR, LAIV, VAR, ZOS]*
   Live virus vaccines are contraindicated one month before and during pregnancy because of the theoretical risk of virus transmission to the fetus. Sexually active women in their childbearing years who receive live virus vaccines should be instructed to practice careful contraception for one month following receipt of the vaccine. On theoretical grounds, inactivated poliovirus vaccine should not be given during pregnancy; however, it may be given if risk of exposure is imminent and immediate protection is needed (e.g., travel to endemic areas). Inactivated influenza vaccine and Tdap are both recommended during pregnancy. Both vaccines may be given at any time during pregnancy but the preferred time for Tdap administration is at 27-36 weeks gestation.