Rxpress Pharmacy DRIVE-THRU

☐ Medicare # _____ ☐ Other 3rd Party ID# _____ ☐ Cash

Screening Questionnaire, Consent and Physician Fax Form

Patient Information: (Patient to complete*)

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

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

*Gender: M or F *Which vaccine(s) would you like to receive today? _____

*Medical Conditions: _____ *Enter Weight if less than 110 lbs: _____

FOR EMERGENCY USE ONLY

*Primary Doctor: _____ *Dr. Phone: _____

* Alt Doctor: _____ *Dr. Phone: _____

I authorize the pharmacist to send copies of my vaccine documents to my primary care provider. Yes ☐ No ☐

Failure to select one of these boxes will result in the vaccine documents being sent to my primary care provider, if known, as state laws & regulations require for my state.

Pharmacy Use Only Dr Fax: _____

Dear Doctor: Today the above patient was vaccinated with the following immunizations at our pharmacy. Please retain for your records.

☐ Influenza Injectable	VIS Date:	☐ Meningococcal	VIS Date:	☐ Zoster (Shingles)	VIS Date:
☐ Pneumococcal	VIS Date:	☐ Td	VIS Date:	☐ Tdap	VIS Date:
☐ Hepatitis B	VIS Date:	☐ Hepatitis A	VIS Date:	☐ Hepatitis A & B	VIS Date:
☐ HPV	VIS Date:	☐ MMR	VIS Date:	☐ Influenza Nasal	VIS Date:
☐ Varicella	VIS Date:	☐ DTaP:	VIS Date:	☐ Hib:	VIS Date:
☐ IPV:	VIS Date:	☐ Other:	VIS Date:	☐ Other:	VIS Date:

Place RX Label Here

Place RX Label Here

Date VIS was given to patient: _____

Date VIS was given to patient: _____

Lot # _____

Exp Date: _____

Site LA or RA (Circle one)

Lot # _____

Exp Date: _____

Site LA or RA (Circle one)

Signature of pharmacist who administered vaccine(s): _____ License #: _____ Date: _____

Patient Information: (Patient to complete this section.)

The following questions will help us determine which vaccines may be given today. If a question is not clear, please ask your pharmacist to explain it.

All Vaccines	**Yes**	**No**	**Don't Know**
Are you sick today?			
Do you have allergies to medications, food (ie. eggs), latex or any vaccine component (i.e. neomycin, formaldehyde, gentamicin, thimerosal, bovine protein, phenol, polymyxin, gelatin, baker's yeast or yeast)?			
Have you ever had a serious reaction after receiving a vaccination?			
Have you received any vaccinations in the past 4 weeks?			
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 (i.e. Gullain-Barre Syndrome)?			
For women: Are you pregnant or could you become pregnant in the next three months?			
For patients over 65 OR have a chronic condition such as Asthma or COPD OR Smoke: Have you received the Pneumococcal or "Pneumonia" vaccine?			
Do you have cancer, leukemia, AIDS, or any other immune system problem?			
Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had X-ray treatments:			
During the past year, have you received a transfusion of blood or blood products, including antibodies?			
For children receiving Flumist: Do you receive long term aspirin therapy?			
For children (2-4yo) receiving Flumist: Do you have a history of wheezing or asthma?			
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 an immunization record card, ask your pharmacist to give you one. Bring this record with you every time you seek medical care.			

I authorize the release of any medical or other information with respect to this vaccine to my healthcare providers, Medicare, Medicaid or other third party payer as needed and request payment of authorized benefits to be made on my behalf to Rxpress Pharmacy.

- I acknowledge that if my insurance does not cover the cost of administering the vaccine at the pharmacy, then payment must be made at the time of the administration of the vaccine.
- I acknowledge that my vaccination record may be shared with federal or state agencies for registry reporting.
- I acknowledge that the pharmacist recommends that vaccinated patients should remain in the waiting area, after the administration of the immunization, for 20 minutes.
- I have read, or have had read to me, the Vaccination Information Sheet (VIS) regarding the vaccine(s). I have had the opportunity to ask questions that were answered to my satisfaction and understand the benefits and risks of the vaccine(s). I consent to, or give consent for, the administration of the vaccine(s). I fully release and discharge Rxpress Pharmacy, it affiliates, their officers, directors, and employees from any liability for illness, injury, loss, or damage which may result there from.

Patient Signature (If under the age of 18: Parent/legal guardian signature)**:** _____