Wegmans Pharmacy Informed Consent/Screening Questionnaire for Immunizations NJ

Name:_____ Date of Birth:_____Age:_____Gender:____Phone # _____

Address:_____ City_____State: ___Zip:_____ Allergies:_____

Vaccine Type needed (circle): Influenza / Pneumonia Primary Care Physician Address:_____
or other Physician: _____ _____

Screening Questionnaire for Vaccination

The following questions help us determine which vaccines you may be given today. If you answer "Yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your pharmacist to explain it.

		YES	NO	UNKNOWN
1.	*Is the person to be vaccinated sick today?*	☐	☐	☐
2.	*Does the person to be vaccinated have an allergy to medications, food, a vaccine component, or latex?*	☐	☐	☐
3.	*Has the person to be vaccinated ever had a serious reaction after receiving a vaccination?*	☐	☐	☐
4.	*Has the person to be vaccinated had a seizure or a brain or other nervous system problem, including Guillan-Barré syndrome?*	☐	☐	☐
5.	*Does the person to be vaccinated have cancer, leukemia, HIV/AIDS, or any other immune system problem?*	☐	☐	☐
6.	***Females only**: Is the person to be vaccinated pregnant or is there a chance they could become pregnant during the next month?*	☐	☐	☐

Medicare Part B Members Only:

MEDICARE#:_____**Part B Effective Date:**_____

(INCLUDE THE LETTER AFTER THE MEDICARE NUMBER. EXAMPLE: "555555555-A")

OR

Insurance Information

Primary Insurance Co:_____ ID#:_____ Grp#:_____

Policy holder Name:_____ ID#:_____

Policyholder DOB:_____Policyholder Address:

I have read, or have had read to me, the Vaccine Information Statement (VIS) developed by the Centers for Disease Control and Prevention (CDC) given with this Consent. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks (including potential side effects and adverse reactions) of the vaccine(s). I consent to, or give consent for, the administration of the vaccine(s) marked below.

Store Stamp here (place on both copies)

☐ **I authorize my vaccination documentation to be forwarded to my primary care/other physician.**
☐ **I do not authorize my vaccination documentation to be forwarded to my primary care/other physician.**

I understand and agree that if I fail to select either option 1 or 2 above that my vaccination documentation will be sent to my primary care or other physician, if identified above. I authorize my vaccination documentation to be forwarded to the collaborative prescribing physician for this program and/or the applicable

State/Commonwealth Department of Health or its equivalent. I understand that it is recommended that I stay in the general area for 15 to 20 minutes after receiving my vaccination in case any immediate reactions occur. I understand that if I experience any side effects, it will be my responsibility to follow up with my physician at my expense. I hereby release the collaborative prescribing physician for this program, Wegmans Food Markets, Inc., its subsidiaries, affiliates, officers,
employees and agents, from any and all liability that might arise from this vaccination on behalf of me, my heirs and personal representatives. I have been provided with a copy of the Wegmans Notice of Privacy Practices. I have been given a copy of this Consent form. Your health is very important to us. Regular preventative care, including vaccines such as the flu shot, can protect you and your family. From time to time, Wegmans Pharmacy may have helpful information regarding services that may be of interest to you. By signing below, I consent to receive healthcare communications from Wegmans Pharmacy at the telephone number(s) listed above regarding the available vaccines, my prescription(s) and those of my dependent minors, and as a follow up to care that I have received or that my dependent minors have received.

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Patient Signature or Legal Representative Relationship of Legal Representative to Patient (if applicable) Date

By signing on this line, I acknowledge that I have received the immunizations listed below and authorize the release of claim information to any third party agencies involved.

- *****For Pharmacy Use Only***** -

Vaccine Name	**Dose (mL)**	**Vaccine Information**			**Route (IM/SQ/IN)**	**Site Given (RA/LA)**	**Date on VIS**	**Admin Date / Date VIS Given to Patient**
		Lot	**Expiration**	**Manufacturer**				

Form and Questions have been reviewed by Immunizer: **Administering/Supervising Pharmacist Signature:**____**RPH**

Intern Signature (if applicable): ______________