FERNDALE PHARMACY

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www.ferndalepharmacy.com

Name: ______________________ Male: _____ Female: _____ Date of Birth: ______________

Address: ______________________ City: ______________ State: ___________ Zip: ______________

Phone: ______________________ Allergies: ______________________ Race: ______________

Primary Care Physician: ______________________ Office Phone Number: ______________________

Screening Questions:

1. Are you sick today? **YES NO**
2. Do you have allergies to medications, food, eggs, yeast, a vaccine component, or latex? **YES NO**
3. Have you ever had a serious reaction after receiving a vaccine? **YES NO**
4. Has any physician or other healthcare professional ever cautioned or warned you about receiving certain vaccines? **YES NO**
5. Do you have a long-term health problem such as heart disease, lung disease, liver disease, asthma, kidney disease, metabolic disease, (e.g., diabetes) anemia or other blood disorders? **YES NO**
6. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem? Have you been diagnosed with rheumatoid arthritis, ankylosing spondylitis, Chronos disease, herpes, or cold sores? **YES NO**
7. In the past three months, have you taken medication that weaken your immune system such as cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments? **YES NO**
8. Have you had a seizure or a brain or other nervous system problem or Guillain Barre? **YES NO**
9. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or anti-viral drug (including acyclovir, famciclovir, or valacyclovir)? **YES NO**
10. For women: Are you pregnant or is there a chance you could become pregnant in the next month? **YES NO**
11. Have you received any vaccinations or TB skin test in the past 4 weeks? **YES NO**
12. Do you have a history of fainting, particularly with vaccines? **YES NO**
13. For Tdap and adult Td: Do you have a cut injury, puncture or open wound that prompted you to get a tetanus shot? **YES NO**
14. Have you had a past reaction to gelatin or triple antibiotic ointment? **YES NO**

Consent

I have read, or have had read to me, the written information regarding the vaccine(s) being administered. 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 have received a copy of the current Vaccine Information Sheet. I, on behalf of myself, my heirs, executors, personal representatives, agents, successors, and assigns hereby agree to release, indemnify, and hold harmless Ferndale Pharmacy. Its subsidiaries, divisions, affiliates, agents, officers, directors, contractors, and employees from all claims arising out of it, in connection with, or any way related to the administration of the vaccine(s). I certify that I am at least 18 years old and hereby give my consent to the pharmacists of Ferndale Pharmacy to administer the vaccine(s). If under 18 years old signature of the parent or guardian is required. I agree to wait near the vaccination location for approximately 15 minutes for observation of the pharmacist.

Name (print) ______________________ Signature: ______________________ Date:

Administration (Pharmacist Use Only)

Vaccine	Product Name	Manufacturer	Lot	Exp Date	Dose	Site of Injection	Date of VIS	Signature of Administrator of Vaccine
INFLUENZA VACCINE	FluCELVAX / FLUAD/OTHER				.5 ml	LD RD		
Prevnar 13	Prevnar 13				.5 ml	LD RD		
Tetanus, Diphtheria Toxoids & Acellular Pertussis (Tdap)	Boostrix, ADACEL				.5 ml	LD RD		
Pneumococcal Polysaccharide (PPSV23)	Pneumovax 23				.5 ml	LD RD		
Pneumococcal Conjugate (PCV13)					.5 ml	LD RD		
Herpes Zoster	Shingrix 1st - 2nd				.5 ml	LD RD		