Vaccination Intake / Screening Form

Patient Information (Please Print Clearly**)**

First Name: _____ Last Name: _____

Date of Birth: ___/___/___ Age:_____ Gender: M F Phone:_____ SSN: _____

Home Address: _____ City: _____

State:_____ ZIP Code:_____ EMAIL _____

Insurance Information: (Fill in ALL that apply)

1. I have MEDICARE (NOTE: COVID VACCINES WILL BE BILLED THROUGH PART B OF YOUR MEDICARE!!)
   MEDICARE PART A/B ID NUMBER _____

2. COMMERCIAL Prescription Insurance Provider: _____
   Are you the primary card holder YES / NO
   BIN#_____ ID#: _____ RxGroup#:_____PCN#_____

3. Family Doctor Name: (PLEASE PROVIDE SO WE MAY SEND YOUR VACCINATION RECORD TO YOUR DOCTOR): Doctor's Name: _____ Phone: _____
   Address: _____ City: _____ State: _____ ZIP: _____

Immunization Screening Questions: Please answer ALL of the questions below. If a question is not clear, please ask the Pharmacist to explain it.	YES	NO
1. Are you sick today?		
2. In the past 3 months, have you tested positive for COVID or are you currently being monitored for Covid-19?		
3. Do you have allergies to Latex, Medication, or Food (i.e. eggs, yeast, neomycin, gentamicin, gelatin, polymyxin, or phenol)?		
4. Have you ever had a serious reaction after receiving a vaccination, including seizures or fainting?		
5. Do you have cancer, leukemia, AIDS, or any other immune system problem or Guillain-Barre Syndrome?		
6. Do you have any health conditions such as heart disease, diabetes, or asthma?		
7. Do you take cortisone, prednisone, other steroids or anti-cancer drugs		
8. During the past year, have you received a blood transfusion or blood products, or received immune(gamma) globulin?		
9. Have you received any vaccinations in the past 4 weeks? (e.g. flu, pneumonia, shingles, etc.)?		
10. For women: Are you pregnant or is there a chance you could become pregnant in the next month?		
11. Have you received a TB Skin test in the past 4 weeks?		
FOR COVID SHOTS ONLY: *Approved use is in patients 65+ and patients 5-64 with at least one underlying condition*		
1. If you are under the age of 65, do you attest to having at least one underlying condition that puts you at high risk for severe outcomes from Covid-19 infection? (list of conditions available at cdc.gov)		
2. Have you ever had a history of myocarditis or pericarditis?		

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 be made directly to Adams Cumberland Pharmacy/Alberts Pharmacy/Big Spring Pharmacy/Holly Pharmacy/Mauch Chunk Pharmacy/Quality Care Pharmacy/West Perry Pharmacy for the services rendered.

-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 vaccination.

-I acknowledge that my vaccination record may be shared with federal, state or city agencies for registry reporting

-I acknowledge that the administration of an immunization does not substitute for an annual check-up with my primary care provider

-I understand that the individual stated above should remain in the vaccine administration area for 30 minutes after the vaccination to be monitored for any potential adverse reactions. I understand if they experience side effects that I should do the following: call pharmacy, contact doctor, call 911. I request that the vaccine be given to the person named above for whom I am authorized to make this request.

-If I am receiving a vaccine through a clinic, I understand that my name, vaccine appointment date and time will be provided to the clinic coordinator.

-I have read or have had read to me the Emergency Use Authorization (EUA) regarding the vaccine. I have had the opportunity to ask questions that were answered to my satisfaction and understand the benefits and risks of the vaccine. I consent to, or give consent for, the administration of the vaccine. Ifully release and discharge Adams Cumberland Pharmacy/Alberts Pharmacy/Big Spring Pharmacy/Holly Pharmacy/Mauch Chunk Pharmacy/Quality Care Pharmacy/West Perry Pharmacy and its employees from any liability for illness, injury, loss or damage which may result from the immunization.

Patient Signature: _____ Date:_____

Parent/Guardian Signature (for minors < 18 years old): _____ Date:_____

Form Reviewed by: _____ Date_____

BOTTOM COMPLETED BY VACCINATOR ONLY:

COVID –PFIZER NAME: **COMIRNATY 12+** VIS DATE: 01/31/25	**COVID-MODERNA** NAME: **SPIKEVAX 12+** VIS DATE: 01/31/25	**FLU (65+) *CIRCLE*** NAME: **FLUZONE HD** MFR: SANOFI **FLUAD HD** MFR: SEQIRUS VIS DATE: 1/31/25	**FLU (<65)** NAME: **FLUARIX** MFR: GSK VIS DATE: 1/31/25	**TDAP** NAME: **BOOSTRIX** MFR: GSK VIS DATE: 1/31/25	**RSV (75+, 50-74)** NAME:**AREXVY** MFR: GSK VIS DATE: 1/31/25	**SHINGLES (50+)** NAME: **SHINGRIX** MFR: GSK VIS DATE: 2/4/22	**PNEUMONIA** NAME: **PREVNAR 20** MFR: GSK VIS DATE: 05/29/25
VOLUME: 0.3 ML	VOLUME: 0.5 ML	VOLUME: 0.5 ML	VOLUME: 0.5 ML	VOLUME: 0.5 ML	VOLUME: 1 ML	VOLUME: 1 ML	VOLUME: 0.5 ML
LOT #	LOT #	LOT#	LOT#	LOT#	LOT#	LOT#	LOT#
EXP DATE	EXP DATE	EXP DATE	EXP DATE	EXP DATE	EXP DATE	EXP DATE	EXP DATE
ADMIN DATE	ADMIN DATE	ADMIN DATE	ADMIN DATE	ADMIN DATE	ADMIN DATE	ADMIN DATE	ADMIN DATE
ROUTE: IM SITE: L / R	ROUTE: IM SITE: L / R	ROUTE: IM SITE: L / R	ROUTE: IM SITE: L / R	ROUTE: IM SITE: L / R	ROUTE: IM SITE: L / R	ROUTE: IM SITE: L / R	ROUTE: IM SITE: L / R
IMMUNIZER:	IMMUNIZER:	IMMUNIZER:	IMMUNIZER:	IMMUNIZER:	IMMUNIZER:	IMMUNIZER:	IMMUNIZER:

PLEASE INCLUDE RX STICKERS BELOW:

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 be made directly to Adams Cumberland Pharmacy/Alberts Pharmacy/Big Spring Pharmacy/Holly Pharmacy/Mauch Chunk Pharmacy/Quality Care Pharmacy/West Perry Pharmacy for the services rendered.

-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 vaccination.

-I acknowledge that my vaccination record may be shared with federal, state or city agencies for registry reporting

-I acknowledge that the administration of an immunization does not substitute for an annual check-up with my primary care provider

-I understand that the individual stated above should remain in the vaccine administration area for 30 minutes after the vaccination to be monitored for any potential adverse reactions. I understand if they experience side effects that I should do the following: call pharmacy, contact doctor, call 911. I request that the vaccine be given to the person named above for whom I am authorized to make this request.

-If I am receiving a vaccine through a clinic, I understand that my name, vaccine appointment date and time will be provided to the clinic coordinator.

-I have read or have had read to me the Emergency Use Authorization (EUA) regarding the vaccine. I have had the opportunity to ask questions that were answered to my satisfaction and understand the benefits and risks of the vaccine. I consent to, or give consent for, the administration of the vaccine. Ifully release and discharge Adams Cumberland Pharmacy/Alberts Pharmacy/Big Spring Pharmacy/Holly Pharmacy/Mauch Chunk Pharmacy/Quality Care Pharmacy/West Perry Pharmacy and its employees from any liability for illness, injury, loss or damage which may result from the immunization.

Patient Signature: _____ Date: _____

Parent/Guardian Signature (for minors < 18 years old): _____ Date: _____

Form Reviewed by: _____ Date _____

BOTTOM COMPLETED BY VACCINATOR ONLY:

COVID –PFIZER NAME: **COMIRNATY 12+** VIS DATE: 01/31/25	**COVID-MODERNA** NAME: **SPIKEVAX 12+** VIS DATE: 01/31/25	**FLU (65+) *CIRCLE*** NAME: **FLUZONE HD** MFR: SANOFI **FLUAD HD** MFR: SEQIRUS VIS DATE: 1/31/25	**FLU (<65)** NAME: **FLUARIX** MFR: GSK VIS DATE: 1/31/25	**TDAP** NAME: **BOOSTRIX** MFR: GSK VIS DATE: 1/31/25	**RSV (75+, 50-74)** NAME:**AREXVY** MFR: GSK VIS DATE: 1/31/25	**SHINGLES (50+)** NAME: **SHINGRIX** MFR: GSK VIS DATE: 2/4/22	**PNEUMONIA** NAME: **PREVNAR 20** MFR: GSK VIS DATE: 05/29/25
VOLUME: 0.3 ML	VOLUME: 0.5 ML	VOLUME: 0.5 ML	VOLUME: 0.5 ML	VOLUME: 0.5 ML	VOLUME: 1 ML	VOLUME: 1 ML	VOLUME: 0.5 ML
LOT #	LOT #	LOT#	LOT#	LOT#	LOT#	LOT#	LOT#
EXP DATE	EXP DATE	EXP DATE	EXP DATE	EXP DATE	EXP DATE	EXP DATE	EXP DATE
ADMIN DATE	ADMIN DATE	ADMIN DATE	ADMIN DATE	ADMIN DATE	ADMIN DATE	ADMIN DATE	ADMIN DATE
ROUTE: IM SITE: L / R	ROUTE: IM SITE: L / R	ROUTE: IM SITE: L / R	ROUTE: IM SITE: L / R	ROUTE: IM SITE: L / R	ROUTE: IM SITE: L / R	ROUTE: IM SITE: L / R	ROUTE: IM SITE: L / R
IMMUNIZER:	IMMUNIZER:	IMMUNIZER:	IMMUNIZER:	IMMUNIZER:	IMMUNIZER:	IMMUNIZER:	IMMUNIZER:

PLEASE INCLUDE RX STICKERS BELOW: