



North Carolina Screening Questionnaire and Consent Form

With us, it's personal.

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 Care Physician (PCP): _____ *Dr. Phone: _____

*PCP address- City _____ State _____ Zip Code _____

Email Address _____

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.	Yes	No	Don't Know
Are you sick today?			
Do you have a long term health problem with heart disease, lung disease, liver disease, asthma, kidney disease, metabolic disorder (e.g. diabetes), anemia or other blood disorders?			
Do you have allergies to medications, food (i.e. eggs), latex or any vaccine component (e.g. neomycin, formaldehyde, gentamicin, thimerosal, bovine protein, phenol, polymyxin, gelatin, baker's yeast or yeast)?			
Have you received any vaccinations or TB skin test, in the past 4 weeks?			
Do you have a history of fainting, particularly with vaccines?			
Have you ever had a serious reaction after receiving a vaccination?			
Do you have a neurological disorder such as seizures or other disorders that affect the brain, or other nervous system problems, or have had a disorder that resulted from a vaccine (e.g. Guillain-Barre Syndrome)?			
Do you have cancer, leukemia, AIDS, or any other immune system problem? Have you been diagnosed with rheumatoid arthritis, ankylosing spondylitis, or Crohn's disease? (in some circumstances you may be referred to your physician)			
In the past 3 months, have you taken medications that weaken your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or have you had X-ray/radiation treatments? (in some circumstances you may be referred to your physician)			
During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin, including antibodies, or an antiviral drug?			
Are you a parent, family member, or caregiver to a new born infant?			
<u>For the Td or Tdap vaccine:</u> Do you have a cut, injury, puncture or open wound that prompted you to get a tetanus shot?*			
<u>For the Zostavax vaccine:</u> Have you had a past reaction to gelatin or triple antibiotic ointment?			
For patients over 65 and patients that have a chronic condition such as Asthma or COPD, or Smoke: Have you received the Pneumococcal or "Pneumonia" vaccine?			
Has any physician or other healthcare professional ever cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a medical setting?*			
<u>For women:</u> Are you pregnant or could you become pregnant in the next three months?			
Did you bring your Immunization Record Card with you?			
Are you currently enrolled in one of our medication adherence programs at Rite Aid (OneTrip Refill, Automated Courtesy Refills, or Rx Messaging- Text, Email, Phone)?			
Have you had the following vaccines?	Yes	No	Don't Know
• Pneumococcal Vaccine-- you may need two different pneumococcal shots			
• Zoster/Shingles Vaccine			
• Whooping Cough (Tdap) Vaccine			

* An immunization must not be given if there is an affirmative answer to these questions

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.

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 Rite Aid.

- 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 or city agencies for registry reporting.
- I acknowledge that the pharmacist recommends that vaccinated patients should remain in the waiting area, for 20 minutes, after the administration of the immunization.
- I acknowledge receipt of Rite Aid's Notice of Privacy Practices for Protected Health Information.
- I acknowledge that the administration of an immunization or vaccine does not substitute for an annual check-up with the patient's primary care physician.
- 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 Rite Aid Corporation, its affiliates, officers, directors, and employees from any liability for illness, injury, loss, or damage which may result there from.

Patient Signature or legal guardian signature: _____ Date: _____

If under the age of 18, parent or legal guardian print name: _____

PHARMACY USE ONLY

<input type="checkbox"/> Influenza Injectable	<input type="checkbox"/> Meningococcal	<input type="checkbox"/> Zoster (Shingles)
<input type="checkbox"/> Pneumococcal	<input type="checkbox"/> Td	<input type="checkbox"/> Tdap
<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Hepatitis A & B
<input type="checkbox"/> HPV	<input type="checkbox"/> MMR	<input type="checkbox"/> Hib:
<input type="checkbox"/> Varicella	<input type="checkbox"/> DTaP:	<input type="checkbox"/> Other:
<input type="checkbox"/> IPV:	<input type="checkbox"/> Other:	



Lot # _____
Exp. Date _____
Site RA or LA- Circle One

Lot # _____
Exp. Date _____
Site RA or LA- Circle One

Signature of pharmacist who administered Vaccine(s) and provided VIS to patient: _____

License #: _____ NPI: _____ Date: _____