Insurance Card:________________ ID:___________________ Group:______________ Clinic –Yes ☐ No ☐

South Carolina Immunization Screening Questionnaire and Consent 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 Care Physician (PCP): _________________________________ *Dr. Phone: ____________________

*PCP address- City ________________________ State______ Zip Code____________

Email Address ____

Screening Questions for All Vaccines	Yes	No	Don't Know
Are you sick today?			
If yes to the above question: Do you have a new fever?			
Do you have a cough?			
Do you have diarrhea?			
Have you been vomiting?			
Have you ever fainted or felt dizzy after receiving a vaccine?			
Have you ever had a reaction after receiving a vaccine?			
Do you have a long-term health problem with heart disease, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g. diabetes) or anemia or another blood disorder?			
Do you have a long-term health problem with lung disease or asthma? Do you smoke?			
Do you have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long-term treatment with drugs such as high-dose steroids, or cancer treatment with radiation or drugs?			
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 ever had a seizure disorder for which you are on seizure medications, a brain disorder, Guillain-Barre syndrome or other nervous system problems?			
Are you a parent, family member, or caregiver to a new born infant?			
For women: Are you pregnant or considering becoming pregnant in the next month?			
Did you bring your Immunization Record Card with you?			
Screening Questions in addition to the above questions, for LIVE Vaccines	**Yes**	**No**	**Don't Know**
Are you currently on home infusions or weekly injections (such as Remicade, Humira, Enbrel, Cimzia, Simponi, Simponi Aria, Xeljanz, Orencia, Arava, Actermra, Cytoxan, Rituxan, adalimumab, infliximab or etanercept), high-dose methotrexate, azathioprine or 6-mercaptopurine, antivirals, anticancer drugs or radiation treatments?			
Have you received any vaccinations or skin tests in the past 4 weeks?			
Have you received a transfusion of blood, blood products or been given a medication called immune (gamma) globulin in the past year?			
Are you currently taking high-dose steroid therapy (prednisone >20mg/day or equivalent) for longer than two weeks?			
For children receiving FluMist®: Do you receive long term aspirin therapy or have a history of wheezing (2-4yo)?			
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*			
• Shingles Vaccine			
• Whooping Cough (Tdap) Vaccine			

This pharmacy is providing necessary vaccines to you in a safe and convenient setting in order to promote adherence to current immunization guidelines recommended by the CDC and ACIP. It does not take the place of an ongoing relationship with your primary care provider to address ongoing medical issues and other types of preventive care. We are providing your primary care provider with records of the vaccine(s) administered here so that your medical records may be complete, but be sure to take your personal record with you to your next appointment as well.

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.

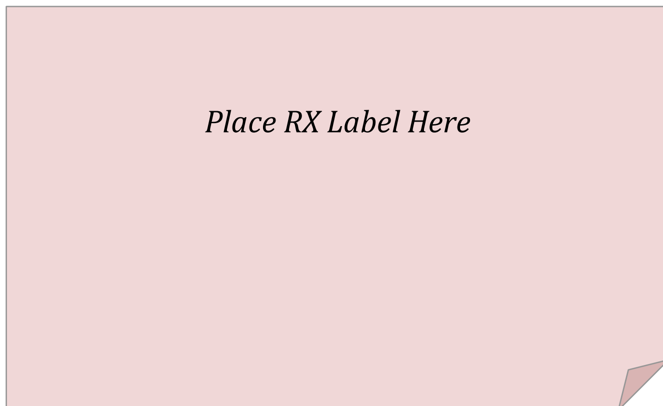
- I acknowledge that if my insurance does not cover the cost of administering the vaccine at the pharmacy, then payment must be made at the time of the administration of the vaccine.
- I acknowledge that my vaccination record may be shared with federal or state or city agencies for registry reporting.
- 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 have read, or have had read or explained to me. the Vaccination Information Sheet (VIS) regarding the vaccine(s). I understand the risks and benefits, and have been provided an opportunity to ask questions, which have been answered to my satisfaction. I wish to receive the vaccine(s). I consent to, or give consent for the pharmacist or pharmacy intern and supervising pharmacist to administer the vaccine(s) and communicate the administration of the vaccine to my primary care practitioner listed above. 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.

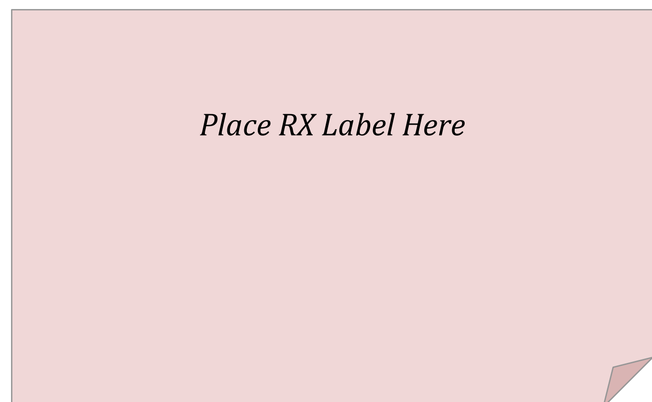
Patient Signature or legal guardian signature ____ Date: ___________

If legal guardian print name ____

PHARMACY USE ONLY

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





Lot #_______________________________

Exp. Date __________________________

Site RA or LA- Circle One

Lot #________________________________

Exp. Date____________________________

Site RA or LA- Circle One

Signature of pharmacist or intern and supervising pharmacist who administered Vaccine(s) and provided the VIS to patient: ____________________________________ License #: ____________ NPI:________________Date: _________