PHARMACA
INTEGRATIVE PHARMACY

IMMUNIZATION SCREENING FORM

Store stamp or EPS Label Here

DATE: **_____**

Name: _____
Address (*Street, City, State, Zip*) :_____
Phone #:_____ **DOB:** _____ **Sex: M F Weight:** _____
Allergies: _____ **Medical Conditions:** _____
Your Primary Care Provider (and phone #, if known) : _____

The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any questions, 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	Don't Know
• Are you sick today?	❑	❑	❑
• Do you have allergies to medications, food or any vaccine?	❑	❑	❑
• Have you ever had a serious reaction after receiving a vaccination?	❑	❑	❑
• Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g. diabetes), anemia, or other blood disorder?	❑	❑	❑
• Do you have cancer, leukemia, AIDS, or any other immune system problem?	❑	❑	❑
• Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?	❑	❑	❑
• Have you had a seizure, brain, or other nervous system problem?	❑	❑	❑
• During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	❑	❑	❑
• For women: Are you pregnant or is there a chance you could become pregnant during the next month?	❑	❑	❑
• Have you received any vaccinations in the past 4 weeks?	❑	❑	❑
• Did you bring your immunization record card with you?	❑	❑	❑
• For injectable medications, which arm would you like your vaccine administered?	R ❑	L ❑	

Please read the following statements and sign below on the signature line.

I have read or have had explained the information provided about the vaccine I am about to receive. I have received and read a Vaccine Information Statement. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of vaccination and ask that the vaccine be given to me or to the person named above for whom I am authorized to make this request. Medicare, I do hereby authorize Pharmaca Integrative Pharmacy to release information and request payment. I certify that the information given by me in applying for payment under Medicare is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf.

X_____ Date: _____

Signature of person to receive vaccine or person authorized to make request (parent or guardian)

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for office use only

SIG CODES for EPS

LAIM (IM, Left Deltoid)	LASC (SC, Left Arm)	RAIM (IM, Right Deltoid)	RASC (SC, Right Arm)
LAID (Intradermal, Left Arm)	RAID (Intradermal, Right Arm)	VACNOS (Nasal Vaccine)	VIVOTIF (Vivotif)

Vaccine	Vaccine	Vaccine
Lot# / Exp.	Lot# / Exp.	Lot# / Exp.
Mfr.	Mfr.	Mfr.
Date on VIS	Date on VIS	Date on VIS
Date given	Date given	Date given
Site	Site	Site

X_____ , _____ Date: _____

Signature AND Title of Administrator

****adapted from Immunization Action Coalition. For details on screening questions, visit http://www.immunize.org/catg.d/p4065.pdf***

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Date:

Name:

This is your prescription hardcopy. Please backtag this copy and file with hardcopies. A new form must be completed for every immunization visit.

Immunizations (Travel)	
❑Hepatitis A (Havrix / Vaqta); # 1 Doses + 0 RF	Havrix: 1mL IM; 0, 6-12 months (2 doses); Vaqta: 1mL IM; 0, 6-18 months (2 doses)
❑Hepatitis B (Engerix HB / Recombivax HB); # 1 Doses + 0 RF	Inject 1mL IM; 0,1,6 months (3 doses)
❑Hep A/Hep B Combo (Twinrix); # 1 Doses + 0 RF	Inject 1mL IM; 0,1,6 months (3 doses)
❑Inactivated Poliovirus (IPOL) # 1 Doses + 0 RF	Inject 0.5mL SQ/IM
❑Japanese Encephalitis (JE Vax); # 1 Doses + 0 RF	Inject 1mL SQ on days 0, 7, 30
❑Japanese Encephalitis (Ixiaro); # 1 Doses + 0 RF	Inject 1mL IM 2 doses, 28 days apart. 2nd dose at least 1 week before travel
❑Typhoid Oral (Vivotif); # 4	Take 1 capsule PO every other day for 4 dose; Refrigerate
❑Typhoid IM (Typhim) # 1 Doses + 0 RF	Inject 0.5mL IM
❑Yellow Fever (YF-Vax) # 1 Doses + 0 RF	Inject 0.5mL SC
❑Rabies (Imovax Rabies / RabAvert); # 1 Doses + 0 RF	Pre-exposure: Inject 1mL IM; 3 doses 0, 7, 21-28 day Post-exposure: not previously immunized - 5 doses days 0, 3, 7, 14, 28 Previously immunized - 2 doses days 0 and 3
❑Meningococcal conjugated (Menactra / Menveo 2-55yo) # 1 Doses + 0 RF	Inject 0.5mL IM
❑Meningococcal polysaccharide (Menomune - 56yo+) # 1 Doses + 0 RF	Inject 0.5mL SQ

Immunizations (Routine)	
Influenza Inactivated ❑Regular ❑Preservative Free ❑Intradermal	IM: Inject 0.5mL IM Intradermal: Inject 0.1mL ID # 1 Doses + 0 RF
Influenza High Dose ❑Regular ❑Preservative Free	Inject 0.5mL IM # 1 Doses + 0 RF
❑Prevnar 13 # 1 Doses + 0 RF	Inject 0.5mL IM
❑Pneumococcal (Pneumovax)	Inject 0.5mL IM/SC # 1 Doses + 0 RF
❑Tdap (Boostrix / Adacel)	Inject 0.5mL IM # 1 Doses + 0 RF
❑Td (Decavac)	Inject 0.5mL IM # 1 Doses + 0 RF
❑Varicella (Varivax); # 1 Doses + 0 RF	Inject 0.5mL SC; 2 doses separated by 4-8 weeks
❑Zoster (Zostavax) # 1 Doses + 0 RF	Inject 0.65mL SC
❑MMR (MMRII) # 1 Doses + 0 RF	Inject 0.5mL SC
❑HPV 9 valent (Gardasil-9); # 1 Doses + 0 RF	Inject 0.5mL IM; 3 doses at 0,1-2, 6 month intervals
❑Shingrix # 1 Doses + 0 RF	Inject 0.5mL IM: 2 doses 0, and 2-6 months interval
❑Other # 1 Doses + 0 RF	

Signature:

Generic Substitution Permitted (Pharmacist)	Dispense as Written (Pharmacist)