PHARMACA®
INTEGRATIVE PHARMACY

IMMUNIZATION SCREENING FORM

Please print and bring this completed form to your appointment.

EPS LABEL HERE

1. PATIENT INFORMATION

Name

Address | City | State | Zip

Phone | DOB | Sex | Weight

Allergies | Medical Conditions

Primary Care Provider (and Phone Number, if known)

2. SCREENING QUESTIONS

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	UNSURE
Are you sick today?	☐	☐	☐
Do you have allergies to food, medications 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?	☐	☐	☐

	YES	NO	UNSURE
Have you had a seizure, brain or other nervous system problem?	☐	☐	☐
In the past year, have you been given a blood transfusion, blood products, immune (gamma) globulin or antiviral drug?	☐	☐	☐
For women: Are you pregnant or could you become pregnant in the next month?	☐	☐	☐
Have you received any vaccinations in the past 4 weeks?	☐	☐	☐
Did you bring your immunization record card with you?	☐	☐	☐
For injectable vaccines: In which arm would you like your vaccine administered?	☐ Right		☐ Left

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

Signature of Patient, Parent or Guardian **Date**

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

Signature AND Title of Administrator **Date**

Adapted from Immunization Action Coalition. For details on screening questions, visit http://www.immunize.org/catg.d/p4065.pdf 7.20

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IMMUNIZATION CASH PRICING SCHEDULE*

☐ Hepatitis A (Havrix)	$ 129.99	☐ Pneumococcal Pneumonia (Prevnar 13)	$ 249.99
☐ Hepatitis B (Engerix B, Recombivax-HB)	$ 119.99	☐ Pneumococcal Pneumonia (Pneumovax 23)	$ 139.99
☐ Hepatitis A/B Combo (Twinrix)	$ 149.99	☐ Td/Tdap (Tenivac, Boostrix, Adacel)	$ 69.99
☐ Meningitis A/C/Y/W-135 (Menactra, Menveo)	$ 149.99	☐ Influenza, Inactivated (Fluzone)	$ T B D
☐ Meningitis B (Trumenba, Bexsero)	$ 204.99	☐ Influenza, High Dose (Fluzone HD)	$ T B D
☐ MMR (M-M-R II)	$ 99.99	☐ Influenza, Recombinant (FluBlok)	$ T B D
☐ HPV (Gardasil 9)	$ 239.99	☐ Influenza, Live (Flumist)	$ T B D
☐ Shingles (Shingrix)	$ 189.99	☐ Other:	$

*Please note that pricing and/or trade names may be unavailable until fall 2020 and/or subject to change.

DAY-OF HEALTH SCREENING QUESTIONS

To be reviewed and completed on the day of your appointment.

1. Do you currently have any of the following symptoms? (Select all that apply)

☐ Fever: _____°F	☐ Chills	☐ Headache
☐ Fever that has lasted over 48 hours	☐ Repeated shaking with chills	☐ New loss of taste or smell
☐ Sore throat	☐ Muscle pain	☐ None of these

2. In the last 2 weeks, have you had contact with someone diagnosed with or presumed to have COVID-19?
If so, we cannot administer a vaccine at this time. Please self-quarantine for the health and safety of others.

3. In the last 2 weeks, have you been in contact with someone who is sick but has not been diagnosed with COVID-19; traveled internationally; or lived in or visited an area where there has been community spread of COVID-19?
If so, this does not necessarily mean you should not be vaccinated. Please be aware that some patients develop self-limited side effects including flu-like symptoms and fever after vaccinations, this is normal and typically resolves 72 hours after the vaccination. You should stay home until symptoms resolve, if they worsen or you develop a cough or shortness of breath you should contact your healthcare provider.

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

I understand that Pharmaca will attempt to bill the pharmacy insurance they have on file for me, and I will be responsible for any remaining costs or copays. I understand that I may contact my insurance before my visit or at any time to confirm my coverage details. I understand that Pharmaca is currently unable to bill major medical plans. All information I have entered is true and correct to the best of my knowledge. If my pharmacy insurance does not cover the full cost of vaccination, I authorize Pharmaca to charge me for the outstanding balance of services rendered.

X _____

Signature of Patient, Parent or Guardian **Date**