IMMUNIZATION INFORMED CONSENT/VACCINE SCREENING FORM

First Name | *MI* | *Last Name*

Phone | *Date of Birth (mm/dd/yyyy)* | *Age* | *M F* *Gender*

Primary Care Provider's Name and Phone Number | *Primary Care Provider's Address* | *State* | *Zip Code*

The following questions will help us determine your eligibility to be vaccinated today.	Yes	No	???
1. Do you have a fever or illness today?	___	___	___
2. Have you experienced any of the following in the past 14 days: fever, unusual cough, unusual shortness of breath?	___	___	___
3. Have you or a household contact been diagnosed with COVID-19 in the past 14 days?	___	___	___
4. Do you have allergies to medications, food (e.g. eggs), latex, or a vaccine component (e.g. bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol or thimerosal)?. If yes, please list the allergies _____	___	___	___
5. Have you ever felt dizzy or fainted after receiving an immunization?	___	___	___
6. Have you ever had a serious reaction to any vaccine in the past?	___	___	___
7. Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-Barré syndrome (a condition that causes paralysis) or other nervous system problem?	___	___	___
8. Are you 65 years of age or older?	___	___	___
9. Do you have a chronic condition or long-term health problem**? If yes, please check all that apply.** ___Anemia ___Asthma ___Diabetes ___Heart disease ___Kidney disease ___Liver disease ___Lung disease ___Obesity ___Smoker	___	___	___
10. If you answered YES to question 8 or 9, have you ever had a pneumonia vaccination?	___	___	___
11. Have you ever had a shingles vaccination (for patients 50 years of age and older only)?	___	___	___
12. Have you ever had an RSV vaccine? (for patients 75 years and older; OR 60-74 years with: any chronic illness checked in #9 other than smoking, or Yes to #14 or #15, or residing in long-term care or nursing home)			
13. **For women**: Are you pregnant or considering becoming pregnant in the next month?	___	___	___
LIVE VACCINES 14. For the past 3 months, have you taken medications that affect your immune system, such as predisone or other steroids, anti-cancer drugs, drugs for the treatment of rheumatoid arthritis, Crohn's disease, psoriasis; or have you had radiation treatments?	___	___	___
15. Do you have cancer, leukemia, lymphoma, HIV/AIDS or any other immune system disorder or are you in contact with anyone who has a severely weakened immune system?	___	___	___
16. Have you received a transfusion of blood or blood products, or been given immune (gamma) globulin in the past year?	___	___	___
17. Are you receiving aspirin therapy or aspirin-containing therapy? (18 years of age and younger only)	___	___	___

I certify I am the patient and at least 18 years of age; the legal guardian of the patient; or a person authorized to consent on behalf of the patient where the patient is not otherwise competent or unable to consent for themselves. I have received a Notice of Privacy Practice for HIPAA. I have read, or have had read to me, the Vaccine Information Statement (VIS) or EUA referred to above. I have been able to ask questions about the vaccine(s), and all my questions have been answered to my satisfaction. I understand the benefits and risks of the vaccine(s). I consent to the administration of the vaccine(s) requested. I authorize the information to be forwarded to my physician, the authorizing physician, State Immunization Information System, or the local Dept. of Health, if applicable. **I agree to stay in the general area for 15-30 minutes** after receiving my vaccination in case any immediate reactions occur. If I experience any side effects, I am responsible for following up with my physician at my expense. On behalf of myself, my heirs, and my personal representatives, I hereby release the pharmacy that is administering the vaccine(s); the subsidiaries and affiliates of the pharmacy; the respective directors, officers, employees, and agents of the pharmacy and its subsidiaries and affiliates; and the owner and/or operator of the clinic site and its directors, officers, employees, and agents from any and all liability that might arise from this vaccination

Patient Signature: _____ Date: _____
(Parent or Guardian, if minor)

Vaccines Provided Today:

☐ Influenza Trivalent ☐ Influenza (65+) ☐ COVID-19 Vaccine (Spikevax) ☐ Shingles (Shingrix)
☐ Pneumococcal PCV20 (Prevnar 20) ☐ Tdap (Boostrix) ☐ RSV (Abrysvo)

Stauffers of Kissel Hill Pharmacy. NPI 1356597074
301 Rohrerstown Rd—Lancaster, PA 17603 PH:717-397-4710

Quincy Harberger M.D. NPI 1346566338
1401 Roosevelt Ave – York, PA 17404

Apply vaccine label here vaccine, lot, exp date, manufacturer, dose (ml)	IM / Route; Right or Left Deltoid / Admin. Site Admin. Date; VIS Date (on form) Administrator*	Apply vaccine label here vaccine, lot, exp date, manufacturer, dose (ml)	IM / Route; Right or Left Deltoid / Admin. Site Admin. Date; VIS Date (on form) Administrator*

By signing as administrator you are confirming that contraindications and side effects have been reviewed and a current VIS was provided to the patient receiving the vaccine. Form revised 9/17/2024

IMMUNIZATION INFORMED CONSENT/VACCINE SCREENING FORM

1. Are you sick today? [all vaccines] There is no evidence that acute illness reduces vaccine efficacy or safety. However, as a precaution, all vaccines should be delayed until moderate or severe acute illness has improved. Mild illnesses with or without fever (e.g., otitis media, "colds," diarrhea) and antibiotic use are not contraindications to routine vaccination.

4. Do you have allergies to medications, food, a vaccine ingredient, or latex? [all vaccines] Gelatin: If a person has anaphylaxis after eating gelatin, do not give vaccines containing gelatin. Latex: An anaphylactic reaction to latex is a contraindication to vaccines with latex as part of the vaccine's packaging (e.g., vial stoppers, prefilled syringe plungers, prefilled syringe caps). For details on latex in vaccine packaging, refer to the package insert (listed at www.fda.gov/vaccines-blood-biologics/vaccines/vaccines-licensed-use-united-states). COVID-19 vaccine: History of a severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a COVID-19 vaccine component is a contraindication to use of the same vaccine type. People may receive the alternative COVID-19 vaccine type (either mRNA or protein subunit) if they have a contraindication or an allergy-related precaution to one COVID-19 vaccine type. Allergy-related precautions include history of 1) diagnosed nonsevere allergy to a COVID-19 vaccine component; 2) non-severe, immediate (onset less than 4 hours) allergic reaction after a dose of one COVID-19 vaccine type (see Note). Not contraindications: Eggs: ACIP and CDC do not consider egg allergy of any severity to be a contraindication or precaution to any egg-based influenza vaccine. Injection site reaction (e.g., soreness, redness, delayed-type local-reaction) to a prior dose or vaccine component is not a contraindication to a subsequent dose or vaccine containing that component.

5. Have you ever felt dizzy or faint before, during, or after a shot? Fainting (syncope) or dizziness is not a contraindication or precaution to vaccination; it may be an anxiety-related response to any injection. CDC recommends vaccine providers consider observing all patients for 15 minutes after vaccination.

6. Have you ever had a serious reaction after receiving a vaccine? [all vaccines] · Anaphylaxis to a previous vaccine dose or vaccine component is a contraindication for subsequent doses of the vaccine or vaccine component. (See question 2.) · Usually, one defers vaccination when a precaution is present unless the benefit outweighs the risk (e.g., during an outbreak).

7. Have you had a seizure or a brain or other nervous system problem? [influenza, Td/Tdap] Tdap: Tdap is contraindicated in people with a history of encephalopathy within 7 days following DTP/DTaP. An unstable progressive neurologic problem is a precaution to using Tdap. For people with stable neurologic disorders (including seizures) unrelated to vaccination, vaccinate as usual. A history of Guillain-Barré syndrome (GBS): 1) Td/Tdap: GBS within 6 weeks of a tetanus toxoid-containing vaccine is a precaution; if the decision is made to vaccinate, give Tdap instead of Td; 2) all influenza vaccines: GBS within 6 weeks of an influenza vaccine is a precaution; influenza vaccination should generally be avoided unless the benefits outweigh the risks (e.g., for those at high risk for influenza complications).

9. Do you have any of the following: a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak? [MMR, VAR, LAIV] LAIV is not recommended for people with anatomic or functional asplenia, a cochlear implant, or cerebrospinal fluid (CSF) leak. Underlying health conditions that increase the risk of influenza complications such as heart, lung, kidney, or metabolic disease (e.g., diabetes) and asthma are precautions for LAIV. MMR: A history of thrombocytopenia or thrombocytopenic purpura is a precaution to MMR.

13. Are you pregnant? [HPV, HepB, IPV, LAIV, MenB, MMR, VAR] Live virus vaccines (e.g., LAIV, MMR, VAR) are contraindicated in pregnancy due to the theoretical risk of virus transmission to the fetus. People who could become pregnant and receive a live virus vaccine should be instructed to avoid pregnancy for 1 month after vaccination. IPV and MenB should not be given except to those with an elevated risk of exposure during pregnancy. HepB: Heplisav-B and PreHevbrio are not recommended during pregnancy, use Engerix-B or Recombivax-HB. HPV is not recommended during pregnancy.

14. In the past 6 months, have you taken medicines that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments? [LAIV, MMR, VAR] Live virus vaccines should be postponed until chemotherapy or long-term highdose steroid therapy concludes. See Note. Some immune mediator and modulator drugs (especially anti-tumor necrosis factor [TNF] agents) may be immunosuppressive. Avoid live virus vaccines in people taking immunosuppressive drugs. A list of such drugs appears in CDCs Yellow Book at wwwwnc.cdc.gov/travel/yellowbook/2024/additional-considerations/immunocompromised-travelers.

15. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem? [LAIV, MMR, VAR] Live virus vaccines are usually contraindicated in immunocompromised people, with exceptions. For example, MMR vaccine is recommended and VAR may be considered for adults with CD4+ T-cell counts of greater than or equal to 200 cells/ mcL. See Note.

16. In the past year, have you received immune (gamma) globulin, blood/blood products or an antiviral drug? [MMR, VAR, LAIV] See Note (schedule) for antiviral drug information (VAR, LAIV). See "Timing and Spacing of Immunobiologics" (www.cdc.gov/vaccines/hcp/acip-recs/general-recs/ timing.html#antibody) for intervals between MMR, VAR and certain blood/blood products, or immune globulin.

17. Are you on long-term aspirin therapy? VAR: Aspirin use is a precaution to VAR due to the association of aspirin use, wild type varicella infection, and Reye syndrome in children and adolescents.

Additional Covid vaccine consideration:

Have you ever been diagnosed with a heart condition (myocarditis or pericarditis) or have you had Multisystem Inflammatory Syndrome (MIS-A or MIS-C) after an infection with the virus that causes COVID-19? Precautions to COVID-19 vaccination include a history of myocarditis or pericarditis within 3 weeks after a dose of any COVID-19 vaccine or a history of Multisystem Inflammatory Syndrome (MIS-C or MIS-A). Myocarditis or pericarditis within 3 weeks after a dose of any COVID-19 vaccine is a precaution: the patient should generally not receive additional COVID-19 vaccine. A person with a history of myocarditis or pericarditis unrelated to vaccination may receive a COVID19 vaccine once the condition has completely resolved. A person with a history of MIS-C or MIS-A may be vaccinated if the condition has fully resolved and it has been at least 90 days since diagnosis. Refer to CDC COVID-19 vaccine guidance for additional considerations for myocarditis, pericarditis, and MIS (see Note).

Additional live vaccine considerations:

Do you have a parent, brother, or sister with an immune system problem? [MMR, VAR] MMR or VAR should not be administered to a patient with congenital or hereditary immunodeficiency in a first-degree relative (e.g., parent, sibling) unless the patient's immune competence has been verified clinically or by a laboratory.

Have you received any vaccinations in the past 4 weeks? [LAIV, MMR, VAR, yellow fever] People given live virus vaccines, such as those listed above, should wait 28 days before receiving another live virus vaccine (wait 30 days for yellow fever vaccine). Inactivated vaccines may be given at the same time or at any spacing interval.

Adapted from: www.immunize.org/catg.d/p4065.pdf / Item #P4065 (11/6/2023)