BLUE DOVE PHARMACY

Screening Questionnaire and Consent Form

Insurance Card: _____ ID: _____ Group: _____

Driver's License #: _____ State ID#: _____ Social Security #: _____

Patient Information: (Patient to complete)

Patient Name: _____ Date of Birth: _____ Age: _____ Phone#: _____

Address: _____ City: _____ State: __ Zip: _____

Email Address: _____

Gender: ☐ Male ☐ Female Ethnicity: _____ Race: _____

How many doses of COVID-19 vaccine have you received? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

If 1+ doses, which vaccine did you receive? ☐ Pfizer (age 12+) ☐ Moderna ☐ Janssen ☐ Pfizer Pediatric (age 5 year-11 year) ☐ Pfizer Pediatric (age 6 month-5 year)

Date of First Dose: _____ Date of Second Dose: _____

Date of Third Dose: _____

If 0 doses or 1 dose of Janssen: Which vaccine would you prefer to receive? ☐ Pfizer ☐ Moderna ☐ Janssen

Which vaccine(s) would you like to receive today? _____

Medical Conditions: _____ Enter Weight if less than 110 lbs.: _____

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

PCP address- City _____ State_____Zip Code _____

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, kidney disease, metabolic disorder (e.g. diabetes), anemia or other blood disorders?			
Do you have a long term health problem with lung disease or asthma? Do you smoke?			
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 in the past 4 weeks?			
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 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? (in some circumstances you may be referred to your physician)			
Do you take prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?			
During the past year, have you received a transfusion of blood or blood products, including antibodies?			
Are you a parent, family member, or caregiver to a new born infant?			
For women: Are you pregnant or could you become pregnant in the next three months?			
Did you bring your Immunization Record Card with you?			
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**			

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 Blue Dove Pharmacy.

- 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 15 minutes, after the administration of the immunization.
- I acknowledge receipt of Blue Dove'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 certify my receipt of the services covered by this claim. I request that payment be made on my behalf. I authorize the holder to release medical information about me to any party involved in payment or their agents.
- 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 Blue Dove Pharmacy and 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 _____

If legal guardian print name _____

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VACCINE	BRAND/MFG	DOSAGE	ROUTE	SITE	LOT	EXP. DATE
COVID-19	☐ Moderna	☐ 0.5mL ☐ 0.25mL	IM	R or L Arm		
COVID-19	☐ Pfizer	☐ 0.2mL ☐ 0.3mL	IM	R or L Arm		
COVID-19	☐ J&J	☐ 0.5mL	IM	R or L Arm		
Influenza ☐ Quad ☐ High Dose ☐ Fluad ☐ Mist		☐ 0.7mL ☐ 0.5mL ☐ 0.25mL ☐ 0.2mL	☐ IM ☐ SQ	R or L Arm Thigh Intranasal		
Other _____						

Clinic – Yes ☐ No ☐

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

License #: _____ NPI #: _____ Date: _____

Signature of Certified Immunizing Technician or Intern or Nurse who administered Vaccine(s): _____