Medical Mall Pharmacy
9 Hospital Dr Unit B3, Toms River, NJ, USA 08755

Screening Questionnaire for Adult Immunization and Consent Form

For Patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does notnecessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it

I. Patient Information:

		Medicare #		Social Security #	
Patient Name:				Allergies:	
Address:				City:	
Phone:	DOB:	Age:	Gender: Male☐ Female☐	State:	Zip:
Primary Care Physician:			Physician Phone:		
Physician Address:					
Race:			Ethnicity:		

I. Vaccination Screen Questionnaire: (Please answer all questions)	Yes	No	Don't Know
1. Are you, the person to be vaccinated, sick today?	☐	☐	☐
2. Do you have allergies to medications, food, a vaccine component, or latex? (Ex: Eggs, bovine protein, gelatin, gentamicin, polymixin neomycin, phenol or thimerosal)	☐	☐	☐
3. Is the person being vaccinated sick today?	☐	☐	☐
4. Have you had a seizure or a brain or other nervous system problems?	☐	☐	☐
5. Has the person to be vaccinated ever had Guillain-Barre syndrome?	☐	☐	☐
6. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
7. Have you received any vaccinations in the past4 weeks?	☐	☐	☐
8. If over 65 years of age or older OR smoke OR have a chronic condition (i.e. asthma or diabetes), have you ever had a pneumococcal, or "Pneumonia" vaccination?	☐	☐	☐
9. Have you received COVID-19 monoclonal antibodies or convalescent plasma in the last 90 days?	☐	☐	☐
10. In the past two weeks, have you tested positive for COVID-19, or are you currently being monitored for COVID-19?	☐	☐	☐
11. In the past two weeks, have you had a known exposure with anyone who tested positive for COVID-19?	☐	☐	☐
12. Have you had a new onset of fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, vomiting, or diarrhea?	☐	☐	☐
13. Allergies	☐	☐	☐

It is important for you to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.

II. Patient Consent:

I understand the benefits and risks of the COVID-19 vaccine as described in the Emergency Use Authorization (EUA) (https://www.cdc.gov/vaccines/covid-19/eua/index.html), a copy of which I was provided with this Consent and Release. I have had a chance to ask questions that were answered to my satisfaction. I request the vaccine to be given to me. I understand the benefits and risks of the vaccine(s). I consent to, or give consent for, the administration of the vaccine(s) and the notification of my primary care physician. I fully release and discharge their offices, directors and employees from any liability for illness, injury, loss or damage which may result there from. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I understand that I should remain in the pharmacy area or instructed location for 15 minutes for observation in case there is an adverse reaction

Patient Signature:

Patient Name: Date:

III. Vaccine Administration (Pharmacist Use ONLY)

I hereby certify that I have verified the screening questionnaire and consent with the above named patient (Initials)

Vaccine: COVID-19 Vaccine	Dose: 0.5ml	Lot Number:	Expire Date:
Manufacture:		Injection Site / Route : LA☐ RA☐ IM☑	
Administered By:		VIS Identification: EUA COVID-19 VACCINE	Date of Publication 02/21
Did an Adverse Reaction occur? Yes☐ No☐			
Contacted VAERS 800-822-7967 Date/Time:		Primary Care Physician contacted: Yes☐ No☐	
Medicare Part B Recipient: Yes☐ No☐		Dose No.: 1st	Appointment Date:
Pharmacist Signature:			Appointment Time: