Grassroots Pharmacy

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Vaccine Administration Screening Form

Patient Name:	Allergies:
Address:	
City/State/Zip Code:	Sex: (M/F)
Date of Birth:	Send copy to provider?
Phone #:	Provider name:
Emergency Contact Name/Phone #:	

	Please answer the following questions:	***Yes***	***No***	***Unsure***
ALL VACCINES	1. Are you sick today?	☐	☐	☐
	2. Are you allergic to neomycin, polymixin B, gentamicin, or arginine?	☐	☐	☐
	Do you have any food allergies (i.e. eggs, gelatin)?	☐	☐	☐
	Are you sensitive to latex?	☐	☐	☐
	Are you allergic to any vaccine component (i.e. thimerosal)?	☐	☐	☐
	3. Have you ever had a serious reaction after receiving a vaccine?	☐	☐	☐
	4. Have you recieved any other vaccines in the past 4 weeks?	☐	☐	☐
	5. Are you 65 years of age or older?	☐	☐	☐
	6. Have you ever had a "pneumonia vaccine"?	☐	☐	☐
	7. Have you ever had a seizure disorder, brain disorder, Gillian-Barre syndrome, or other nervous system problem?	☐	☐	☐
	8. Have you ever had a lymph node removed from your underarm-area? If yes, please specify: Right Left	☐	☐	☐
	9. FOR FEMALE PATIENTS: Are you pregnant or considering becoming pregnant in the next 3 months?	☐	☐	☐

I have recieved the current Vaccine Information Statement(s) for the requested vaccine(s) and have read or have had explained tome the information about the requested vaccine(s). I have had a chance to ask questions that were answered to my satisfaction. I certify that I am (1) the patient and at least 18 years old, (2) the parent or legal gardian of the minor party, or (3) the legal guardian of the patient and hereby give my consent to the staff at Grassroots Pharmacy to administer the vaccine(s) requested above. I understand that it is not possible to predict all possible side effects or complications with vaccines. I understand the benefits and risks of the requested vaccine(s) and request that it be given to me or to the person named above for whom I am authorized to make this request. Further, I acknowledge that I have been advised to remain near the vaccination location for approx. 20 minutes after the administration for observation by the pharmacist. I hereby and for my heirs, executors, administrators, successors, and assigns release, acquit, and forever discharge Grassroots Pharmacy, PLLC, its subsidiaries and affiliates, and each of their agents, employees, officers, directors, servants, successors, heirs, executors, and administrators (collectively "Grassroots Pharmacy) of and from any and all claims, actions, causes of action, demands, rights, damages, injuries, and property damage and the consequences thereof resulting or to result from the immunization. If the below vaccine(s) are administered at an off-site clinic, by signing I authorize Grassroots Pharmacy to release immunization record(s) to my employer upon request. I acknowledge that I have read this release form prior to signing it and that I understand its contents. I understand and agree that I will not be able to sue the physician who approved the protocol or Grassroots Pharmacy for and injury or property damage I may suffer as a result of the immunization.

Patient Signature: _____ Date: _____

Insurance ID:_____ Rx Group:_____ Rx BIN:_____ Rx PCN:_____

Below For Pharmacy Use Only

Vaccine	Exp Date	Lot #	Manufacturer	Dose	Inj. Site	Route	Needle Size	VIS Date	Date VIS Given

Immunizer Signature: _____ License #: _____ Administration Date/Time: _____

Adverse Reactions? Y N (If yes, please explain on reverse side of sheet) Offsite Locations: _____

PRIVATE AND CONFIDENTIAL: This communication and any attachments contain individual Protected Health Information. The disclosure of such information is governed by the Health Insurance Portability and Accountability Act. If you have recieved this communication from the sender in error, please notify the sender immediately and destroy the communication recieved.