Scan R	NCIR	List	Dr. M List	Fax Doctor / Fax #

A to Z Pharmacy

North Carolina Immunization Questionnaire and Consent Form

Patient Name: _____ Date of Birth: _____ Age: _____ Gender: M F Email Address: _____
Address: _____ City,State, ZIP: _____ Phone: _____
Primary Care Physician Name, Phone: _____
Vaccine(s) Requested: _____ Weight **(only if under 110 lbs):** _____ Medical Conditions: _____

The following questions will ensure your safety when receiving a vaccine. If a question is not clear, ask your pharmacist to explain it.	**Yes**	**No**
Are you sick today?		
Do you have a long-term problem with heart, lung, asthma, kidney disease, diabetes, metabolic disorder, anemia, liver disease, or blood disorder?		
Are you allergic to any medications, food, latex, gelatin, triple antibiotic ointment, or any vaccine component (neomycin, gentamicin, bovine protein, polymyxin, yeast)? Please list allergies: _____		
Have you received any vaccinations or TB skin tests in the past 4 weeks?		
Has a doctor or other healthcare professional ever cautioned you about getting certain vaccines or receiving vaccines outside of a medical setting?		
Have you ever had a serious reaction (including fainting) after receiving a vaccine?		
Do you have a neurological disorder (seizures or other disorders that affect the brain), nervous system problems, or have you had a disorder that resulted from a vaccine (Guillain-Barre Syndrome)?		
Do you have cancer, leukemia, AIDS, or any other immune system problem?		
Are you taking any medication for rheumatoid arthritis, ankylosing spondylitis, or Crohn's disease?		
In the past 3 months, have you taken medications that weaken your immune system (Cortisone, prednisone, other steroids, anticancer drugs) or have you had radiation treatments?		
In the past year, have you had a transfusion of blood, blood products, immune globulin, antibodies, or an antiviral drug?		
For Tdap or Td: Do you have a cut, injury, puncture, or open wound that prompted you to get a Tetanus vaccine?		
For women: Are you pregnant, or could you become pregnant in the next two months?		

By signing, 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 A to Z 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 20 minutes after administration of the vaccine. I acknowledge that it is my responsibility to see appropriate follow-up care for any adverse reaction that may result from this vaccine. 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 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 the administration of the vaccine(s). I fully release and discharge A to Z Pharmacy, its affiliates, officers, directors, and employees from any liability, injury, loss, or damage that may result therefrom.

I authorize the pharmacist to send copies of my vaccine documents to my primary care provider. **Yes** **No**

Patient Signature or legal guardian signature: _____ Date: _____

If under the age of 18, parent or legal guardian print name: _____

Series #: _____ of _____ Injection Site: **LEFT** **RIGHT** Deltoid Route: **IM** **SQ** VACCINE LABELS HERE	RX LABEL

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

VIS Date _____ License # 18931 9273 NPI 1720244239 1356643290 Date _____