Universal Immunization Intake Form

Katterman's SAND POINT PHARMACY

CASCADIA PHARMACY WALLINGFORD

Date:			
Name:		DOB:	
Address: (Street, City, State, Zip)			
Email:		Age:	
Phone:	TEXT OK: Y / N	Sex: M / F /_____	Weight Over 66lbs: Y / N
Allergies:	Medical Conditions:		
Your Primary Care Provider (and phone #, if known):			

SELECT YOUR VACCINES (MARK AS MANY AS NEEDED – IF YOU AREN'T SURE, ASK PHARMACY STAFF)

SEASONAL VACCINES (check a box if you have a specific preference)

- ☐ **COVID-19**
  - ☐ Moderna (Spikevax), 6M - 11YO
  - ☐ Moderna (Spikevax), 12+
  - ☐ Novavax, 12+
- ☐ **Influenza**
  - ☐ Fluad, 65+
  - ☐ Flucelvax, 6mo+
  - ☐ FluMist, 2-49
- ☐ **RSV**
  - ☐ Abrysvo
  - ☐ Arexvy
  - ☐ Mresvia

ROUTINE VACCINES

- ☐ **Chicken Pox (Varivax)**
- ☐ **DTap (Daptacel, tetanus &**
- ☐ **Haemophilus Influenza B**
- ☐ **Hep A & B (Twinrix)**
- ☐ **Hepatitis A (Havrix)**
- ☐ **Hepatitis B (Heplisav-B)**
- ☐ **Hepatitis B (Engerix)**
- ☐ **HPV (Gardasil)**
- ☐ **MenABCWY (Penbraya)**
- ☐ **Meningococcal MenACWY**
- ☐ **Meningococcal-B**
  - ☐ Bexsero
  - ☐ Trumenba
- ☐ **MMR (M-M-R II)**

ROUTINE VACCINES

- ☐ **Pneumococcal**
  - ☐ Capvaxive 21
  - ☐ Pneumovax 23
  - ☐ Prevnar 20
- ☐ **Polio (IPOL)**
- ☐ **RSV**
  - ☐ Abrysvo
  - ☐ Arexvy
  - ☐ Mresvia
- ☐ **Shingles (Shingrix)**
- ☐ **Tetanus (Td - Tenivac)**
- ☐ **TDaP (Boostrix, Adacel)**

TRAVEL VACCINES

- ☐ **Cholera** (Vaxchora)
- ☐ **Japanese Encephalitis** (Ixiaro)
- ☐ **Polio** (iPOL)
- ☐ **Rabies** (Rabavert)
- ☐ **Tic borne Encephalitis** (TicoVac)
- ☐ **Typhoid**
  - ☐ Vivotif (Oral, Live)
  - ☐ Typhim (Injectable)
- ☐ **Yellow Fever** (YF-VAX)
- ☐ **Chikungunya**
  - ☐ Vimkunya

- ☐ **OTHER:**

please CONTINUE TO BACK OF THE FORM*

Vaccine	Vaccine	Vaccine
Lot# / Exp	Lot# / Exp	Lot# / Exp
Mfr.	Mfr.	Mfr.
Date on VIS	Date on VIS	Date on VIS
Date Provided (if different from Date of Service)	Date Provided (if different from Date of Service)	Date Provided (if different from Date of Service)
Site L Deltoid / R Deltoid / NASAL	Site L Deltoid / R Deltoid / NASAL	Site L Deltoid / R Deltoid / NASAL
Route IM / SC / NASAL	Route IM / SC / NASAL	Route IM / SC / NASAL

Name and Title of Administrator (IF DIFFERENT FROM PRESCRIBING PHARMACIST) **Date of Service**

Authorization for Above Vaccines (FLU / COVID SHOTS Via Standing Order per DR T S Kwan-Gett)

Prescriber's Signature: _____ (Substitution Permitted)

Pharmacists Name: _____

REQUIRED FOR STATE IMMUNIZATION REGISTRY REPORTING

RACE	**ETHNICITY**
☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Native Hawaiian / Other Pacific Islander ☐ Other / Unknown	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Other / Unknown

Scan here For Vaccine Information:

INSURANCE (complete if we do not have your information on file)

RXBIN:	PCN:	GROUP:	ID#:
Medicare Patients ONLY	SSN:		Medicare Part B ID#:
Offsite Clinic ONLY	Clinic Name:		Clinic Address:

SCREENING QUESTIONS

	YES	NO	UNSURE
Are you sick today?	☐	☐	☐
Do you have allergies to medications, food, a vaccine component, or latex?	☐	☐	☐
Have you ever had a serious reaction after receiving a vaccine?	☐	☐	☐
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?	☐	☐	☐
Are you on long term aspirin therapy?	☐	☐	☐
Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
Do you have a parent, brother, or sister with an immune system problem?	☐	☐	☐
In the past 6 months, have you taken medications 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?	☐	☐	☐
Have you had a seizure or a brain or other nervous system problem?	☐	☐	☐
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?	☐	☐	☐
In the past year, have you received immune (gamma) globulin, blood / blood products, or an antiviral drug?	☐	☐	☐
Are you pregnant?	☐	☐	☐
Have you received any vaccinations in the past 4 weeks?	☐	☐	☐
Have you ever felt dizzy or faint before, during or after a shot?	☐	☐	☐
Are you anxious about getting a shot today?	☐	☐	☐

CONSENT

Please read the following statements and sign below on the signature line.

I acknowledge that I have read, or have had explained to me, the Vaccine Information Statement (VIS) or other informational material regarding the vaccine(s) I am receiving today. I understand the benefits and risks associated with the vaccine(s) and have had an opportunity to ask questions, which have been answered to my satisfaction.

I understand that, as with any medical treatment, there is a risk of adverse reactions, including but not limited to allergic reactions. I understand that the pharmacist or healthcare provider administering the vaccine may be required to share my immunization record with state or local immunization registries, my primary care provider, and/or other healthcare entities as required by law.

I consent to the administration of the vaccine(s) by the pharmacist or qualified healthcare provider and release the pharmacy, its employees, and agents from any liability arising from the vaccination, except in cases of negligence or willful misconduct.

If applicable, I authorize the pharmacy to bill my insurance provider for the cost of the vaccine and administration. I

Signature of Patient OR for Minors - Parent or Guardian **Date**

**Your signature is an attestation of the minor's correct age and DOB

Parent/Guardian Full Name (please print):_____Contact Phone #: _____