ROSAUERS CONSENT AND RELEASE - INJECTABLE VACCINATIONS

Vaccine(s) Requested:

Last Name of Patient | First | Middle | Birth Date ___/___/____ | Age (____) | Sex ☐M ☐F

Permanent Address | City | State | Zip | Home Phone (____)____-____

Primary Insurance | Insurance ID # or Medicare B # *(include numbers and letters)* | Primary Care Physician *(Please provide if you want records sent to him/her)* | Phone #

I acknowledge that I understand the benefits and risks of the requested vaccination as described in the Vaccine Information Sheet, a copy of which is provided with this Consent and Release. I confirm that Rosauers, on behalf of its pharmacy operations in all divisions, ("Rosauers") has answered to my satisfaction all of my questions about the vaccine and the vaccination procedure. I request and consent that the vaccination be given, as I direct Rosauers, either to me or to the person named above, a minor for whom I represent that I am authorized to sign this Consent and Release. I understand that I am giving Rosauers permission to release any medical or other information necessary to my physician, Medicare, Medicare HMO, or insurance company or immunization registry, as applicable, to enable Rosauers to process my insurance claims with respect to the vaccination. I, for myself (and for the recipient of the vaccination, if the recipient is a minor), my heirs, executors and assigns hereby release Rosauers and its divisions and affiliates and their respective officers, directors, employees, agents and representatives from any and all claims arising out of or in connection with the quality of the above-described vaccine(s) as provided by the manufacturer and any negligence of Rosauers in connection with the related injection of the vaccination. I understand that the laws of my state may affect my remedies in connection with this vaccination.

X _____ Signature of Person to Receive Vaccine(s)/Parent or Guardian of Minor | _____ Date | _____ Print Name of Parent or Guardian/Phone #

Please answer these questions by checking the boxes. If the question is not clear, please ask the pharmacist.		Yes	No	Don't Know
Vaccine History	**All Patients:** *How long has it been since your last **TETANUS** shot?*	_____ yrs		
	Any Patient who Smokes OR has Asthma, Diabetes or Heart Disease OR is 65 years or older: *Have you ever received the **PNEUMONIA** vaccine? If Yes, When?* _____			
	Patients 60 years of age or older: *Have you ever received the **SHINGLES** vaccine?*			
All	**1. In the past 14 days have you had a fever of 100.4° or greater, unusual coughing, unusual shortness of breath, diagnosed with COVID-19 or a household member with COVID-19?**			
	2. Do you have a **serious allergy** to ANY medications or food? (Example: Eggs, Gelatin, Thimerosal, Neomycin, Gentamicin). If Yes, please list:_____			
	3. Have you ever had a **serious reaction or fainted after receiving any vaccination**?			
	4. Do you have sensitivity to **latex**? (Example: gloves or bandages)			
	5. For women: Are you pregnant or are you considering becoming pregnant?			
Tdap	**6.** Do you have a seizure disorder or a brain disorder?			
Live	**7.** Have you received any vaccination in the past 4 weeks? *Which one(s)?*_____			
	8. Do you have cancer, leukemia, HIV, active shingles or any other **immune system problem**?			
	9. Do you take prednisone, oral steroids, anticancer drugs, antiviral medications or medications that affect the immune system?			
	10. During the past year, have you received a transfusion of blood or blood products, been given a medicine called immune (gamma) globulin, or had radiation therapy?			

BELOW FOR PHARMACY USE ONLY

Check Box to Confirm Patient Identity Verified ☐ **Check Box to Confirm Vaccine/Drug to be administered Verified** ☐

Vaccine	Lot # of Vaccine	Exp Date	Manufacturer	Dosage	Site of Injection	Time	VIS Date
Fluzone			Sanofi		IM L / R Deltoid		
					L / R		
					L / R		

Signature of Pharmacist:_____**RPh** **Date VIS provided to patient:**_____

ROSAUERS PHARMACY #_____ **ROSAUERS PHARMACY PHONE #**_____

WA ONLY:

Substitution Permitted _____ Dispense As Written _____

Signature of Administrator_____

KEEP FOR 10 YEARS

****FILE WITH PRESCRIPTION**

HARDCOPIES**

Information for Health Professionals about the Screening Questionnaire for Adults

Are you interested in knowing why we included a certain question on the Screening Questionnaire? If so, read the information below. If you want to find out even more, consult the references listed at the bottom of this page.

1. Are you sick today? *[all vaccines]*
There is no evidence that acute illness reduces vaccine efficacy or increases vaccine adverse events (I). However, as a precaution with moderate or severe acute illness, all vaccines should be delayed until the illness has improved. Mild illnesses (such as upper respiratory infections or diarrhea) are NOT contraindications to vaccination. Do not withhold vaccination if a person is taking antibiotics.

2. & 4. Do you have allergies to medications, food, a vaccine component, or latex? *[all vaccines]*
History of anaphylactic reaction such as hives (urticaria), wheezing or difficulty breathing, or circulatory collapse or shock (not fainting) to a vaccine component or latex is a contraindication to some vaccines. For example, if a person experiences anaphylaxis after eating eggs, do not administer influenza vaccine, or if a person has anaphylaxis after eating gelatin, do not administer MMR or varicella vaccine. Local reactions are not contraindications. For a table of vaccines supplied in vials or syringes that contain latex, go to www.cdc.gov/vaccines/pubs/pinkbook/downloads/ appendices/B/ latex-table.pdf. For an extensive list of vaccine components, see reference 2.

3. Have you ever had a serious reaction after receiving a vaccination? *[all vaccines]*
History of anaphylactic reaction (see question 3) to a previous dose of vaccine or vaccine component is a contraindication for subsequent doses (I). Under normal circumstances, vaccines are deferred when a precaution is present. However, situations may arise when the benefit outweighs the risk (e.g., during a community pertussis outbreak).

5. For women: Are you pregnant or is there a chance you could become pregnant during the next month? *[MMR, LAIV, VAR, ZOS]*
Live virus vaccines (e.g., MMR, VAR, ZOS, LAIV) are contraindicated one month before and during pregnancy because of the theoretical risk of virus transmission to the fetus. Sexually active women in their childbearing years who receive live virus vaccines should be instructed to practice careful contraception for one month following receipt of the vaccine. On theoretical grounds, inactive poliovirus vaccine should not be given during pregnancy; however, it may be given if risk of disease is imminent and immediate protection is needed (e.g., travel to endemic areas). Use of Td or Tdap is not contraindicated in pregnancy. At the provider's discretion, either vaccine may be administered during the 2nd or 3rd trimester. (I, 3, 4, 5, 7, 8)

6. Have you had a seizure or a brain or other nervous system problem? *[influenza, Td/Tdap]*
Tdap is contraindicated in people who have a history of encephalopathy within 7 days following DTP/DTaP given before age 7 years. An unstable progressive neurologic problem is a precaution to the use of Tdap. For people with stable neurologic disorders (including seizures) unrelated to vaccination, or for people with a family history of seizure, vaccinate as usual. A history of Guillain-Barre syndrome (GBS) is a consideration with the following: I) Td/Tdap: if GBS has occurred within 6 weeks of a tetanus-containing vaccine and decision is made to continue vaccination, give Tdap instead of Td if no history of prior Tdap; 2) Influenza vaccine (TIV/LAIV): if GBS has occurred within 6 weeks of a prior influenza vaccine, vaccinate with TIV if at high risk for severe influenza complications.

7. Have you received any vaccinations in the past 4 weeks? *[LAIV, MMR, VAR, yellow fever]*
If the person to be vaccinated was given either LAIV or an injectable live virus vaccine (e.g., MMR, VAR, ZOS, yellow fever) in the past 4 weeks, they should wait 28 days before receiving another vaccination of this type. Inactivated vaccines may be given at any spacing interval if they are not administered simultaneously.

8. Do you have cancer, leukemia, AIDS, or any other immune system problem? *[LAIX, MMR, VAR, ZOS]*
Live virus vaccines (e.g., LAIV, measles-mumps-rubella [MMR], varicella [VAR], zoster [ZOS]) are usually contraindicated in immunocompromised people. However, there are exceptions. For example, MMR vaccine is recommended and varicella vaccine should be considered for adults with CD4+ T-lymphocyte counts of greater than or equal to 200 cells/uL. Immunosuppressed people should not receive LAIV. For details, consult the ACIP recommendations (3,4,5).

9. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments? *[LAIV, MMR, VAR, ZOS]*
Live virus vaccines (e.g., LAIV, MMR, VAR, ZOS) should be postponed until after chemotherapy or long-term high-dose steroid therapy has ended. For details and length of time to postpone, consult the ACIP statement (1,5). To find specific vaccination schedules for stem cell transplant (bone marrow transplant) patients, see reference 6. LAIV can be given only to healthy non-pregnant people younger than age 50 years.

10. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? *[LAIV, MMR, VAR]*
Certain live virus vaccines (e.g., LAIV, MMR, VAR) may need to be deferred, depending on several variables. Consult the most current ACIP recommendations for current information on intervals between antiviral drugs, immune globulin or blood product administration and live virus vaccines. (1)

Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder? *[LAIV]*
People with any of these health conditions should not be given the intra-nasal live attenuated influenza vaccine (LAIV). Instead, they should be vaccinated with the injectable influenza vaccine.

References:

1. CDC. General recommendations on immunization, at www.cdc.gov/vaccines/pubs/acip-list.htm.
2. Table of Vaccine Components: www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/excipient-table-2.pdf.
3. CDC. Measles, mumps, and rubella – vaccine use and strategies for elimination of measles, rubella, and congential rubella syndrome and control of mumps. MMWR 1998; 47 (RR-8).
4. CDC. Prevention of varicella: Recommendations of the Advisory Committee on Immunization Practices. MMWR 2007; 56 (RR-4).
5. CDC. Prevention and control of influenza – recommendations of ACIP, at www.cdc.gov/flu/ professionals/vaccination.
6. CDC. Excerpt from Guidelines for preventing opportunistic infections among hematopoietic stem cell transplant recipients. MMWR 2000; 49 (RR-10), www.cdc.gov/vaccines/pubs/downloads/b_hsct-recs.pdf.
7. CDC. Notice to readers: Revised ACIP recommendation for avoiding pregnancy after receiving a rubella-containing vaccine. MMWR 2001; 50 (49).
8. CDC. Prevention of pertussis, tetanus, and diphtheria among pregnant and postpartum women and their infants: Recommendations of the ACIP. MMWR 2008; 57 (RR-4).