TAYLOR DRUG PHARMACY
Established in 1936

Taylor Drug
Immunization Encounter Form

(all information required for reporting to state immunization database)

Please have ready your health insurance card or Medicare card (red, white, and blue paper card).

Patient Name: _____ **Birth Date:** _____/_____/_____ **Age:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:**_____

Phone: (_____ **)** _____-_____ **Gender:** ☐ Male ● ☐ Female **Mother's Maiden Name:** _____

Race(s): ☐ African American ● ☐ American Indian ● ☐ Asian ● ☐ Hispanic ● ☐ Pacific Islander ● ☐ White ● ☐ Other

Drug Allergies: _____

Which vaccine(s) do you wish to receive today (check all wanted)?

COVID-19: ☐ J&J® ☐ Moderna® ☐ Pfizer® (12+) ☐ Pfizer® Pediatric (5-11)
☐ J&J® booster ☐ Moderna® booster ☐ Pfizer® (12+) booster

☐ Hepatitis A ☐ Hepatitis B ☐ Influenza (Flu) ☐ Measles/Mumps/Rubella (MMR)
☐ Meningitis ☐ Pneumonia ☐ Shingles ☐ Tetanus/Diphtheria/Pertussis (Tdap)

Please answer these questions concerning the person receiving immunizations today	**Yes**	**No**	**Don't Know**
1. Are you sick today?	☐	☐	☐
2. Do you have allergies to medications, food, a vaccine component, polyethylene glycol (PEG), or latex?	☐	☐	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☐	☐
4. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
5. Do you have a parent, brother, or sister with an immune system problem?	☐	☐	☐
6. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had x-ray treatments?	☐	☐	☐
7. Have you had a seizure or a brain or other nervous system problem?	☐	☐	☐
8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
9. Have you received any vaccinations in the past 4 weeks?	☐	☐	☐
10. **For woman:** Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
11. Are you on long-term aspirin therapy?	☐	☐	☐
12. Do you have a chronic condition or long-term health problems? **If yes, check all that apply:** ☐ Anemia, ☐ Asthma, ☐ Diabetes, ☐ Heart Disease, ☐ Kidney Disease, ☐ Liver Disease, ☐ Lung Disease, ☐ Obesity, ☐ Smoker	☐	☐	☐
13. If age 50 years or older have you received a shingles vaccine?	☐	☐	☐
14. If age 65 or older or have any medical condition from question 12, have you received a pneumonia vaccination?	☐	☐	☐

I have been given a copy and have read or had explained to me, the information contained in the Vaccine Information Statement(s) about the disease(s) and vaccine(s). Any questions I had were answered to my satisfaction. I understand the benefits and risk of the vaccine(s) and request that the vaccine(s) indicated be given to me or the person for whom I am authorized to make this request. I certify that I have been offered a copy or been given the opportunity to read the Notice of Privacy Practices. I agree that the immunizations may be shared with schools, day care centers, health care providers, and others to verify immunization status, for public health studies, or when medically necessary. I hereby release Taylor Drug and their employees from all claims arising from such immunizations.

By signing below, I certify that I am 18 years old or older; the legal guardian or the patient; or a person authorized to consent on behalf of patient where the patient is not otherwise competent or unable to consent for themselves. I agree to stay in the general area for 15 minutes after receiving my vaccination in case any immediate reactions occur. On behalf of myself, my heirs, and my personal representatives, I hereby release the pharmacy that is administering the vaccine(s), as well as its employees and agents of the pharmacy from any and all liability that might arise from this vaccination.

Signature: _____ Date: _____/_____/_____

If Signature **NOT** patient's, Print Name: _____ DOB:_____/_____/_____ Relation: _____

Below for pharmacy use only

Vaccine	**Dose**	**Site**	**Lot #**	**VIS Date**
☐ J&J®, ☐ J&J® booster	0.5mL			
☐ Moderna® 1 2 ☐ Moderna® booster	0.5mL 0.25mL			
☐ Pfizer® (12+) 1 2 ☐ Pfizer® (12+) booster	0.3mL 0.3mL			
☐ Pfizer® (5-11) 1 2	0.2mL			

Place Rx Sticker Here

Administrator's Signature: _____ Date: _____/_____/_____

Updated 11/12/2021

Are you interested in knowing why we included a certain question on the screening checklist? If so, read the information below. If you want to find out even more, consult the references in Notes below.

1. Are you sick today?

There is no evidence that acute illness reduces vaccine efficacy or increases vaccine adverse events (1). 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. Do you have allergies to medications, food, or any vaccine?

History of anaphylactic reaction such as hives (urticaria), wheezing or difficulty breathing, or circulatory collapse or shock (not fainting) from a previous dose of vaccine or vaccine component is a contraindication for further doses. 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 (e.g., a red eye following instillation of ophthalmic solution) are not contraindications. For an extensive list of vaccine components, see reference 2.

3. Have you ever had a serious reaction after receiving a vaccination?

History of anaphylactic reaction (see question 2) to a previous dose of vaccine or vaccine component is a contraindication for subsequent doses (1). 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 measles outbreak).

4. Do you have cancer, leukemia, AIDS, or any other immune system problem?

Live virus vaccines (e.g., MMR, varicella, zoster [shingles], and LAIV) 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/μL. Immunosuppressed persons should not receive LAIV. For details, consult the ACIP recommendations (3, 4, 5).

5. Do you have a parent, brother, or sister with an immune system problem?

MMR or VAR vaccines should not be administered to persons who have a family history of congenital or hereditary immunodeficiency in first-degree relatives (i.e., parents and siblings), unless the immune competence of the potential vaccine recipient has been substantiated clinically or verified by a laboratory

6. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had x-ray treatments?

Live virus vaccines (e.g., MMR, varicella, zoster, LAIV) 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 persons younger than age 50 years.

7. Do you have a seizure, brain, or other nervous system problem?

Tdap is contraindicated in persons 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 persons with stable neurologic disorders (including seizures) unrelated to vaccination, or for persons with a family history of seizure, vaccinate as usual. A history of Guillain-Barré syndrome (GBS) is a consideration with the following: 1) 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; 3) MCV4: avoid vaccinating persons unless in recommended risk groups.

8. During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin?

Certain live virus vaccines (e.g., MMR, varicella) may need to be deferred, depending on several variables. Consult the most current ACIP recommendations for current information on intervals between immune globulin or blood product administration and MMR or varicella vaccination. (1)

9. Have you received any vaccinations in the past 4 weeks?

If the person to be vaccinated was given either LAIV or an injectable live virus vaccine (e.g., MMR, varicella, zoster, 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.

10. For women: Are you pregnant or is there a chance you could become pregnant during the next month?

Live virus vaccines (e.g., MMR, varicella, zoster, LAIV) are contraindicated in the 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, inactivated 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. (1, 3, 4, 5, 7, 8)

11. Are you on long-term aspiring therapy?

Aspirin therapy is a precaution to VAR.

12. 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?

Persons with any of these health conditions should not be given the intranasal live attenuated influenza vaccine (LAIV). Instead, they should be vaccinated with the inject-able 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 congenital 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), https://www.cdc.gov/mmwr /preview/mmwrhtml/rr4910a1.htm
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 tetanus, diphtheria and pertussis among pregnant women: Provisional ACIP recommendations for use of Tdap vaccine, at www.cdc.gov/vaccines/recs/provisional/downloads/tdap-preg.pdf.