☐ Self Pay
☐ Private Insurance
☐ Medicare #:_____

Taylor Drug
76 North 1100 East
American Fork, Utah 84003

Screening Questionnaire for Immunizations and Consent

(all information required for reporting to state immunization database)

Patient's Name (Print): _____ **Date of Birth:**_____/_____/_____
Address:_____**City:**_____ **State:**_____ **Zip:**_____
Phone:_____ **Allergies:**_____
Mother's Maiden Name:_____ **Race:**_____

The following question will help us determine which vaccines may be given today. If a question is not clear, please ask the pharmacist or health care provider to explain it:

		Yes	No	Don't Know
1.	Are you sick today?	☐	☐	☐
2.	Do you have allergies to medications, food (i.e. eggs), or any vaccines?	☐	☐	☐
3.	Have you ever had a serious reaction after receiving a vaccination?	☐	☐	☐
4.	Do you have cancer, leukemia, AIDS, or any other immune system problem?	☐	☐	☐
5.	Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had x-ray treatments?	☐	☐	☐
6.	During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin?	☐	☐	☐
7.	Have you received any vaccinations in the past 4 weeks?	☐	☐	☐
8.	Do you have a past history of Guillain-Barre Syndrome?	☐	☐	☐
9.	Are you allergic to the mercury-based preservative thimerosal?	☐	☐	☐
10.	**For women:** Are you pregnant or is there a chance you could become pregnant in the next three months?	☐	☐	☐

Your Physician (Primary Care Provider):_____

Did you bring your immunization record card with you? (circle one) Yes No

It is important for you to have a personal record of your vaccinations. If you don't have a record card, ask your pharmacist to give you one. Bring this record with you every time you seek medical care. Make sure your health care provider records all your vaccinations on it.

Consent for administration of vaccine(s):

☐ Influenza - VIS Date: _____
☐ Hepatitis A - VIS Date: _____
☐ Tetanus Td - VIS Date: _____
☐ Tetanus Tdap - VIS Date: _____
☐ Zoster - VIS Date: _____
☐ Live, Intranasal Influenza - VIS Date: _____
☐ Hepatitis B - VIS Date: _____
☐ Pneumonia - VIS Date: _____
☐ Meningococcal - VIS Date: _____

I have read, or have had read to me the vaccination information sheet (VIS) regarding the vaccine(s) marked above. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s). I consent to, or give consent for, the administration of the vaccine(s) marked above and the notification of my Doctor (primary care provider), and the Utah Statewide Immunization Information System (USIIS). I fully release and discharge Taylor Drug Inc., its affiliates, officers, directors, and employees from any liability for illness, injury, or damage which may result therefrom.

Medicare Part B Customers: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

Patient Signature: _____ **Today's Date:** _____/_____/_____

Site of Vaccination (circle one) Right Arm Left Arm Other: _____

Vaccination Manufacturer & Lot Number: _____ Exp: _____

Signature of pharmacist or intern who administered the vaccine: _____

TAYLOR DRUG
PHARMACY
Established in 1936
76 North 100 East, American Fork, Utah 84003-2952

Understanding the Screening Questionnaire for Adult Immunization

The information below has been adapted from Epidemiology & Prevention of Vaccine-Preventable Diseases, WL Atikson et al., editors, CDC, 6th edition, Jan 2000, and CDC's guide to Contraindications to Childhood Vaccinations, Oct. 2000.

1. Are you sick today?

There is no evidence that acute illness reduces efficacy or increases vaccine adverse events (1,2). However, with moderate or severe acute illness, all vaccines should be delayed until the illness has improved. Mild illness (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 other 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.

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 (4). Under normal circumstances, vaccines are deferred when a precaution is present. However, situations may arise when the benefit outweighs the risk (e.g., community measles outbreak).

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

Live virus vaccines (e.g., MMR, varicella) are usually contraindicated in immunocompromised people. However, there are exceptions. For example, MMR is recommended for asymptomatic HIV-infected individuals who do not have evidence of severe immunosuppression. For details, consult the ACIP recommendations (5,6).

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

Live virus vaccines (e.g., MMR, varicella) 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). To find specific vaccination schedules for stem cell transplant (bone marrow transplant) patients, see reference 7.

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

Live virus vaccines (e.g., MMR, varicella) may need to be deferred, depending on several variables. Consult the ACIP Statement "General Recommendations on Immunization" (1) or 2000 Red Book, p. 390 (2), for the most current information on intervals between immune globulin or blood product administration and MMR or varicella vaccination.

7. For women: Are you pregnant or is there a chance you could become pregnant in the next 3 months?

Live virus vaccines (e.g, MMR, varicella) are contraindicated prior to and during pregnancy due to the theoretic risk of virus transmission to the fetus. Sexually active women in their child-bearing years who receive MMR or varicella vaccination should be instructed to practice careful contraception for 3 months following MMR vaccination and 1 month following varicella vaccination (5,8). Inactivated vaccines may be given to pregnant women whenever indicated.

10. Have you received any vaccination in the past 4 weeks?

If two live virus vaccines (e.g., MMR, varicella yellow fever) are not given on the same day, the doses must be separated by at least 28 days. Inactivated vaccines may be given at any spacing interval if they are not administered simultaneously. (For travelers, consult the Yellow Book (9).

CDC. General recommendations on immunization. MMWR 1994; 34 (RR-1).
AAP. 2000 Red Book: Report of the Committee on Infectious Diseases. 25th ed. Elk Grove Village, IL: APP, 2000
Visit the website: www.cdc.gov/nip/publications/pink/vaxcont.pdf
CDC. Guide to contraindications to childhood vaccinations. Oct 2000. Available online at www.cdc.gov/nip/recs/containdications.pdf
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).
CDC. Prevention of varicella: updated recommendations of the ACIP. MMWR 1999; 48 (RR-6).
CDC. Guidelines for preventing opportunistic infections among hematopoietic stem cell transplant recipients. MMWR 2000; 49 (RR-10).
CDC. Prevention of varicella. MMWR 1996; 45 (RR-11).
CDC. Health Information for International Travel, 1999-2000, DHHS, Atlanta, GA.
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