SCREEN CONSENT FORM

Pfizer Moderna Flu

CARVAJAL PHARMACY
Caring is our business

Last Name	First Name	Date of Birth	Age	SSN	Male / Female

St. Address	City	State	Zip	Phone

Insurance	Ins. ID	Ins Rx Grp	Ins PCN #	Ins Bin #	Clinic Location/Facility

Race: White Asian Native American/Alaska Native Black

Ethnicity: Hispanic Non-Hispanic

	Vaccination Screen Questionnaire. Check YES or NO to answer the following questions.	Select one: Yes	Select one: No
FLU (1 - 4)	1. Are you feeling sick today?		
	2. Do you have allergies to any of the following? ☐ Eggs **(Fluad)** ☐ PEG **(found in laxatives & mRNA vaccines)** ☐ Other _____ If you are allergic to eggs, have you had symptoms other than hives in the past? **e.g. swollen face, throat, or tongue, trouble breathing, lightheadedness, or frequent vomiting. (30 min observation required)**		
	3. Have you ever had a serious reaction after receiving a vaccination? **This would include, swollen face, throat, or tongue, trouble breathing, lightheadedness, or frequent vomiting and the use of an EpiPen or caused hospitalization. (30 min observation required)**		
	4. Have you ever had Guillain-Barre Syndrome (muscle weakness) within 6 weeks after receiving a flu vaccine?		
COVID (1 – 15)	5. Have you been treated for COVID-19 with monoclonal antibodies or convalescent serum? **(must wait 90 days after treatment)**		
	6. Do you have a bleeding disorder or take any blood thinners? **e.g. Eliquis, Xarelto, Aspirin, Warfarin**		
	7. Have you received dermal fillers? **(swelling at filler site may occur after administration of Moderna)**		
	8. Do you have a weakened immune system? **e.g. HIV infection, cancer, organ/stem cell transplant**		
	9. Do you take immunosuppressive drugs or therapies?		
	10. Do you have any other condition which may cause moderate or severe immunosuppression or recommendation by physician?		
	11. Male between 12 and 29 years of age **(risk of myocarditis and pericarditis)**		
	12. Have you been diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection? **(must wait 90 days after diagnosis)**		
	13. Are you 18-64 years old and at high risk for COVID-19 infection based on medical history? **e.g. current or previous smoker, obesity, diabetes, heart, kidney, liver or lung disease, etc.**		
	14. Are you 18 years or older and at high risk for COVID-19 exposure because of occupational or institutional settings? **e.g. teachers, grocery store, healthcare, jail, nursing facilities, etc.**		
	15. Have you ever received a dose of COVID-19 vaccine? 1st DATE 2nd DATE If yes, which vaccine product did you receive? (Circle one) Pfizer Moderna J & J Other _____		

_____ **Patient Consent**: I have read, or have had read to me, the Vaccination Information Statement (VIS) and/or Emergency Use Authorization information regarding the vaccines(s) I am about to receive. 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) and the notification of my primary care physician. I fully release, indemnify, defend and hold harmless Carvajal Pharmacy, it's pharmacists, directors, and employees from any liability for illness, injury, loss or damage which may result there from. 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.

_____ **(ImmTrac2) Consent: Texas Dept. of State Health Services (DSHS) Immunization Registry for consent & release of vaccine records:** The DSHS registry consolidates immunization records for public health purposes giving access to Texas healthcare providers (physicians), Texas hospitals, Texas schools, State & local public health districts, state agencies having legal custody of individual, a payer currently authorized by the Texas Dept. of Insurance to operate in Texas for immunization records related to a specific individual covered under the payer's policy. ImmTrac2 contact info: (800) 252-9152 * (512) 776-7284 * Fax (866) 624-0180 * www.ImmTrac2.com **By my initial & signature below, I grant consent for my registration to include my information in the Texas immunization Registry (ImmTrac2)**. Pharmacies are mandated to report all COVID-19 vaccinations to ImmTrac2.

Patient Name: _____ **Patient or Rep. Signature:** _____ **Date:** _____

RPh/RN: _____ **CPhT:** _____

(circle one) Pfizer 0.3ml / Moderna 0.5ml

☐ 1st dose ☐ 2nd dose ☐ 3rd dose

LOT:_____ EXP: _____

IM- R / L Deltoid

COVID LABEL

(circle one) Fluad / Flucelvax - Seqirus

LOT:_____ EXP:_____

IM 0.5ml - R / L Deltoid

FLU LABEL