THE PHARMACY at MAGRUDER HOSPITAL

FOR PHARMACY USE ONLY
Cardholder Name_____
RX ID number_____
RX Bin number_____
Rx PCN number_____
Rx Group number_____

Vaccine Health Questionnaire, Consent Form and VAR

Last Name	First Name	MI	Date of Birth	Age
Home Address	City		State	Zip Code
				Patient / Volunteer / MAGRUDER Employee / Student
Phone #	Family Physician			Indicate which (above)

Vaccine Requested (circle): Influenza

The following question will help us determine eligibility to be vaccinated today	YES	NO
1. Are you feeling sick today or have a moderate to high fever?		
2. Do you have allergies to medications, food, vaccine components or latex? (Examples: eggs, bovine protein, gelatin, gentamicin, polymixin, neomycin, phenol, yeast, or thimerosal)		
3. Have you received any vaccination or skin tests in the past 4 weeks? If yes, please list.		
4. Have you ever had a serious reaction to any vaccine? If yes, please list.		
5. Have you ever had a seizure, brain or nervous system disorder or Guillain-Barre Syndrome?		
6. Are you pregnant or do you plan on becoming pregnant in the next month?		
7. Do you have a chronic condition or long term health problem such as heart disease, lung disease, asthma, kidney disease, diabetes, anemia or other blood disorders?		
8. Have you ever had a pneumonia vaccination?		
9. Have you ever had a Shingles (Shingrix) vaccination? (patients 55 years of age and older)		
10. Are you currently on home infusion, weekly injections, steroid therapy, anticancer drugs or radiation therapy?		
11. Do you have cancer, leukemia, lymphoma, HIV/AIDS or any other Immune system disorder or are you in contact with anyone who has a severely weakened immune system?		
12. Have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug in the past year?		
IF YOU ANSWERED YES TO ANY OF THE ABOVE, PLEASE REVIEW WITH YOUR VACCINATING ADMINISTRATOR		

Consent and Waiver: I have read or had explained to me the information on the Vaccine Health Questionnaire. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of receiving the above listed vaccine(s) and have received, read and/or had explained to me the Vaccine Information Statement on the above listed vaccine(s). I ask the above listed vaccine(s) be given to me or the person named above for whom I am authorized to make this request.

Patient/Legal Guardian Signature **Date**

For clinician use only:

Vaccinating Administrator Name (Print) **Vaccinating Administrator Signature** **Administration Date**

Vaccine	Lot #	Exp. Date	Manufacturer	NDC	Dosage	Site (LA/RA)	Route (IM/SQ)	VIS Date
Influenza	Z7275	6/2021	GSK	58160-0885-52	0.5mL	LA RA	IM SQ	8/15/2019
						LA RA	IM SQ	
						LA RA	IM SQ	

Please forward to L. Desloover – Infection Control