Caldwell
Pharmacy~Home Medical Equipment~Gifts
(870) 238-7085 M-F 8:30-6; Sat. 8:30-12
www.caldwellmax.com

Pharmacist Immunization Program
Improving Arkansas wellness.

Name: _____ Date of Birth: _____ Age: _____

Gender (circle one): Male / Female SSN: _____

Race: _____ Ethnicity (circle one): Hispanic or Latino/Non-Hispanic or Latino

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone#: _____ Family Doctor: _____

Method of payments: Cash / Medicare / Private Insurance (please provide card to pharmacy)

Insurance Cardholder Name: _____ Cardholder Date of Birth: _____

Screening Questions (if you answer yes, please explain below) **PLEASE CIRCLE**

1. Are you feeling sick today or have a fever?	Yes	No
2. Are you currently in quarantine for testing positive for COVID-19 or for known exposure to COVID-19?	Yes	No
3. Do you have allergies to medications, food, a vaccine component, or latex?	Yes	No
4. Have you ever had a serious reaction after receiving a vaccination?	Yes	No
5. <18 years old: Have you had a well-child visit with your pediatrician in the last 12 months?	Yes	No
6. Do you have long-term health problems with heart, lung, kidney or metabolic disease (e.g.diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Are you on long-term aspirin therapy?	Yes	No
7. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	Yes	No
8. Do you have a parent or sibling with an immune system problem?	Yes	No
9. In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Chron's disease, or psoriasis; or have you had radiation treatments?	Yes	No
10. Have you had a seizure or a brain or other nervous system problem?	Yes	No
11. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	Yes	No
12. For females: Are you pregnant or is there a chance you could become pregnant during the next month?	Yes	No
13. Have you received any vaccinations in the past 4 weeks?	Yes	No
14. Have you had shingles in the last 6 months?	Yes	No
15. Have you ever had a shingles vaccine before?	Yes	No
16. Have you ever had a pneumonia vaccine before? If so, at what age? _____	Yes	No

Consent and waiver: All of the information I have provided is correct. I consent to the staff to administer the medication(s) mentioned below. I have reviewed the vaccine information sheet (s) and understand the benefits and risks of receiving this medication and choose to assume this risk. I fully release and discharge the standing order physician and the pharmacy, its affiliations and their officers, and employees from any illness, injury, loss, or damage that may result there from. I acknowledge that ***I have received a copy of the pharmacy's privacy policies according to HIPAA***. I assign payment of authorized insurance benefits due to me to be paid to the pharmacy and will pay any copay or deductible that result. I consent the release of medical information when necessary for billing, reimbursement, and medical protocol. I also allow for the pharmacy to report any medications received to the appropriate state vaccine registry and allow the registry to share with other provicers. I am aware that an immunization certified student pharmacist might be administering this medication. **I agree to wait near the vaccination area for approximately 20 minutes to receive treatment in case of adverse reaction.**

Vaccine: _____

Signature of patient or guardian: _____