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 Phone#: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Payment: Cash/Medicare/Private Insurance Insurance Cardholder Name & 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. Do you have allergies to medications, food, a vaccine, component of vaccine, or latex?	Yes	No
3. Have you ever had a serious reaction to something for which you were treated with epinephrine or Epipen or for which you had to go to the hospital?	Yes	No
4. 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
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	Yes	No
6. Do you have a parent or sibling with an immune system problem?	Yes	No
7. 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
8. Have you had Guillain-Barre' Syndrome (GBS), seizures or other brain/nervous system problems?	Yes	No
9. 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
10. Have you had Multisystem Inflammatory Syndrome (MIS)? Defer COVID vaccination for at least 90 days. The decision for COVID-19 vaccination should be between the patient, guardian, clinical team, or a specialist.	Yes	No
11. Have you received a hematopoietic cell transplant (HCT) or CAR-T cell therapy since receiving a COVID-19 vaccine?	Yes	No
12. Did you develop myocarditis or pericarditis after any dose of COVID-19 vaccine? Do you have a history of myocarditis or pericarditis prior to COVID-19 vaccination?	Yes	No
13. Do you have a bleeding disorder or are you taking blood thinners?	Yes	No
14. For females: Are you pregnant, breastfeeding or is there a chance you could become pregnant during the next month?		
15. Have you received any vaccinations in the past 4 weeks?	Yes	No
16. Have you had shingles in the last 6 months?	Yes	No
17. Have you ever had a shingles vaccine before?	Yes	No
18. Have you ever had a pneumonia vaccine before? If so, at what age? _____	Yes	No
19.<18 years old: Have you had a well-child visit with your pediatrician in the last 12 months?	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 providers. I am aware that an immunization certified student pharmacist or technician 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: _____