Screening Questionnaire: Please answer questions by checking the banes.			ormed Conse	nt ioi iiiiii	lumzation				1			
Month Address Which arm do you prefer for vectine? Primary Care Provider Manne: Primary Care Provider Manne: Primary Care Provider Manne: Primary Care Provider Address: Primary Care Provider Manne: Primary Care State State Care Provider Manne: Primary Care Note: Primary Care Note: Primary Care Provider Manne: Primary Care Note: Pr	Po	ark J	ohn			05/02/199	97	24	ØM			
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Nome Address (Ity State 12p Phone 8 (Them of Cite) Which arm do you prefer for veccine? (please circle) Left Right Frimary Care Provider Name: Vaccine reguested:	4716 Main Street Pittsburgh PA 15213 (412)						412,22	Z- 4	-761			
Spread of the company of the property with the company of the primary Care Provider Name:	State 7in Phone # THor						one # 🗆 Home	The	II			
[please circle] Left Right Primary Care Provider Address: Screening Questionnaive: Please answer questions by checking the boxes. Screening Questions—NOTE: FCOMPLETED ONLINE, REVIEW ANSWERS WITH PATIENT TO ENSURE NO CHANGES 1. Are you sick today? 2. please fist: 3. Have you seve had a serious reaction or fainted after receiving any vaccination? 4. Do you have sensitivity to latox (e.g., gloves or bandages)? 5. Do you have a sensitivity to latox (e.g., gloves or bandages)? 5. Do you have a sensitivity to latox (e.g., gloves or bandages)? 5. Do you have a sensitivity to latox (e.g., gloves or bandages)? 5. Do you have a sensitivity to latox (e.g., gloves or bandages)? 7. Do you have a medical condition or take medication(s) that may weaken your immune system? If yes, please list: 7. Do you have a medical condition or take medication(s) that may weaken your immune system? If yes, please list: 8. For women: Are you pregnant or are you considering becoming pregnant in the next month? 9. Do you have a medical condition or take medication(s) that may weaken your immune system? If yes, please list: 9. Immunitation Needs—NOTE-COVID-19 VACCINC CANNOT BE ADMINISTERED WITH OTHER IMMUNIZATIONS 9. Plates check all that apply to you: 9. Plates check all that apply to you: 9. Plates check all that apply to you: 10. How many years has it been since your last TETANUS vaccine? 11. Patients 550 and older: Have you received the MINOCOCCOCC vaccine? If yes, when? 12. Plates in the province of t							ht IF LESS than	66 pou	nds:	Lbs		
Screening Questionnaire: Please answer questions by checking the boxes. Screening Questions - NOTE: IF COMPLETED ONLINE, REVIEW ANSWERS WITH PATIENT TO ENSURE NO CHANGES Are you ske today?	Primary Care Provider Name: Vaccine requested:											
Screening Questions - NOTE: IF COMPLETED ONLINE, REVIEW ANSWERS WITH PATIENT TO ENSURE NO CHANGES	(pleas	se circle) Left Right	Primary Care	Provider Addre	!ss:			-:				
1. Are you sick today? 2. please list: 3. Have you ever had a serious reaction or fainted after receiving any vaccination? 4. Do you have sensitivity to latex (e.g. glows or bandages)? 5. Do you have sensitivity to latex (e.g. glows or bandages)? 6. For women: Are you pregnant or are you considering becoming pregnant in the next month? 7. Do you have a nemedical condition or take medication(s) that may weaken your immune system? If yes, please list: 9. Please feed, all that apply to you: 8. Asthma Diabetes Heart Disease Tobacco Smoker Systems or older If you observe the deal with a place of the control of the place of the control of the place of the control of the place of	Screen	ing Questionnaire: Please answer	questions by checkin	ng the boxes.								
1. Are you sick today? 2. please list: 3. Have you ever had a serious reaction or fainted after receiving any vaccination? 4. Do you have sensitivity to latex (e.g. glows or bandages)? 5. Do you have sensitivity to latex (e.g. glows or bandages)? 6. For women: Are you pregnant or are you considering becoming pregnant in the next month? 7. Do you have a nemedical condition or take medication(s) that may weaken your immune system? If yes, please list: 9. Please feed, all that apply to you: 8. Asthma Diabetes Heart Disease Tobacco Smoker Systems or older If you observe the deal with a place of the control of the place of the control of the place of the control of the place of	Screen	ning Questions - NOTE: IF COMPLI	ETED ONLINE, REVI	EW ANSWERS V	WITH PATIENT	TO ENSURE NO CH	IANGES		Yes	,	10/	
Do you have a serious allergy to ANY medications or food (e.g. eggs, gelatin, thimerosal, neomycin, gentamicin, etc.)? If yes, please list: Do you have seristivity to latex (e.g. gloves or bandages)?										1	र्ज	
2. Have you ever had a serious reaction or fainted after receiving any vaccination? 3. Have you have sensitivity to latex (e.g. gloves or bandages)? 5. Do you have a seiture disorder or a brain disorder? (Tdop only) 6. For womer: Are you pregnant or are you considering becoming pregnant in the next month? 7. Do you have a medical condition or take medication(s) that may weaken your immune system? If yes, please list: 7. Do you have a medical condition or take medication(s) that may weaken your immune system? If yes, please list: 8. Please check all that apply to you: 8. Please check all that apply to you: 9. Patients 50 and older: Have you ever received a PNEUMOCOCCAL vaccine? 9. Patients 50 and older: Have you ever received the SHINGLES vaccine? 10. How many years has it been since your last TEAMUS vaccine? 11. Patients 50 and older: Have you ever received the SHINGLES vaccine? 12. Patients 30 and older: Have you received the HPV (Human Papillomavirus) vaccine? 13. Hepatitiss A — Hepatitiss B — MMR (Measles, Mumps, Rubelia) — Travel Vaccines — Other: 14. Patients aged 11 to 23: Have you received a meningitis vaccine? 15. Patients 36 and under: Have you would like more information about? 16. Pease indicate which vaccine(s) you would like more information about? 17. Patients 45 and under: Have you would like more information about? 18. Patients aged 11 to 23: Have you received a meningitis vaccine? 19. Patients aged 10 to 23: Have you received a meningitis vaccine? 19. Patients aged 10 to 23: Have you received a meningitis vaccine? 19. Pray signature below, Lonsent to the administration of the vaccine(s) by a pharmacist or a supervised student pharmacist or technician, where permitted by law or statisfied pray or you would be more information about? 19. You yierpature below, Lonsent to the administration of the vaccine(s) by a pharmacist or a supervised student pharmacist or technician, where permitted by law or statisfied pharmacist and to be contacted at the number provided above regardin		Do you have a serious allergy to	ANY medications or	r food (e.g. eggs	, gelatin, thime	rosal, neomycin, ge	entamicin, e	tc.)? If yes,			_/	
A. Do you have a setzure disorder or a brain disorder? (Tago anly)	2.	please list:								[9	
A. Do you have a setzure disorder or a brain disorder? (Tago anly)	-	Howe you ever had a serious rea	ction or fainted afte	er receiving any	vaccination?			-		4		
5. Do you have a seiture disorder or a brain disorder? [Tidap only] 6. For women: Are you pregnant or are you considering becoming pregnant in the next month? 7. Do you have a medical condition or take medication(s) that may weaken your immune system? If yes, please list: 9. Do you have a medical condition or take medication(s) that may weaken your immune system? If yes, please list: 9. Do you have a medical condition or take medication(s) that may weaken your immune system? If yes, please list: 9. Patients On the dead of the above, have you ever received a PNEUMOCOCCAL vaccine? If yes, when? 9. Patients 50 and older: Have you ever received the SHINGLES vaccine? 10. How many years has it been since your last TETARUS vaccine? 11. Patients 45 and under: Have you would like more information about? 12. Patients aged 11 to 23: Have you received the HPV (Human Papillomavirus) vaccine? 13. Please indicate which vaccine(s) you would like more information about? 14. Please indicate which vaccine(s) you would like more information about? 15. Prease indicate which vaccine(s) you would like more information about? 16. Hepatitis A Hepatitis A	_				VBCCIII G GOIT:				-			
6. For women: Are you pregnant or are you considering becoming pregnant in the next month? 7. Do you have a medical condition or take medication(s) that may weaken your immune system? If yes, please list:	_			SERVEY SERVEY					П			
To you have a medical condition or take medication(s) that may weaken your immune system? If yes, please list:	_				gnant in the ne	xt month?						
Travel Vaccine Please check all that apply to you:							, please list:		_	-		
Plases check all that apply to you:	7.								U	L	9	
8. Asthma	lmmuni		ACADELIA DA DADENIA DE SACE	E ADMINISTERE	D WITH OTHE	RIMMUNIZATIONS			Yes	No	Unsure	
If you checked any of the above, have you ever received a PNEUMOCOCCAL vaccine? 9. Patients 50 and older: Have you ever received the SHINGLES vaccine? 10. How many years has it been since your last TETANUS vaccine? 11. Patients 45 and under: Have you received the HPV (Human Papillomavirus) vaccine? 12. Patients aged 11 to 23: Have you received the HPV (Human Papillomavirus) vaccine? 13. Hepatitis A Hepatitis B MMR (Measles, Mumps, Rubella) Travel Vaccines Other: Informed Consent: Please read and sign. Please indicate which vaccine(s) you would like more information about? 13. Hepatitis A Hepatitis B MMR (Measles, Mumps, Rubella) Travel Vaccines Other: Informed Consent: Please read and sign. Py my signature below, I consent to the administration of the vaccine(s) by a pharmacist or a supervised student pharmacist or technician, where permitted by law or state/feder pulsance, employed by Contoso Companies or one of its affiliated pharmacies and to be contacted at the number provided above regarding other immunications for which I always or a significance in the part of the vaccine of the va				oro 🗖 To	hacca Smokar	CI 65 Ventre or	r older		п	4	_	
10. How many years has it been since your last TETANUS vaccine? 11. Patients 45 and under: Have you received the HPV (Human Papillomavirus) vaccine? 12. Patients aged 11 to 23: Have you received a meningitis vaccine? 13. Please indicate which vaccine(s) you would like more information about? 13. Hepatitis A Hepatitis B MMR (Measles, Mumps, Rubella) Travel Vaccines Other: Informed Consent: Please read and sign. by my signature below, I consent to the administration of the vaccine(s) by a pharmacist or a supervised student pharmacist or technician, where permitted by law or state/feder commissions from the consent to the companies or one of its affiliated pharmacist and to be contacted at the number provided above regarding other immunizations for which I always or commission, resulting or arising from my receipt of this vaccination. Lunderstand that: 11) have voluntarily chosen to review the vaccination and understand that 1 am obligation or pays for all products and senders received, if applicable. 2) I may be responsible for payment after the date of service if the product or service is billed to my medical benefit. 3 my clearly also an authorized to execute this consent form or I am the parent/guardian of the minor patient. 4) I will immediately alert the pharmacist of any medical condition which may adversely affect my personal health or effectiveness of the vaccine. 9) I have been counseled about potential side effects after vaccination, when they may occur, and when all should be seek treatment. I am responsible for following up with my physician at my expense if lexeptineric any side effects. 6) I should remain in the area for 1 initiates after the vaccination for observation. Plantary of the vaccination of the vaccination for becaused to 7) I have been counseled about potential side effects. 6) I should remain in the area for 1 initiates after the vaccination for becaused to 7) I have been counseled about potential side effects after vaccination, when they may occur and the vaccination of t	٥.							145 A	_	. ,		
11. Patients 45 and under: Have you received the HPV (Human Papillomavirus) vaccine? Patients aged 11 to 23: Have you received a meningitis vaccine? Please indicate which vaccine(5) you would like more information about? Hepatitis A	9.	Patients 50 and older: Have you	ever received the S	HINGLES vaccin	e?					8		
12. Patients aged 11 to 23: Have you received a meningitis vaccine? Please indicate which vaccine(s) you would like more information about? Please indicate which vaccine(s) you would like more information about? Please indicate which vaccine(s) you would like more information about? Please indicate which vaccine(s) you would like more information about? Please indicate which vaccine(s) you would like more information about? Please indicate which vaccine(s) you would like more information about? Please indicate which vaccine(s) you would like more information about? Please indicate which vaccine(s) you would like more information about? Please indicate which vaccine(s) you would like more information about? Please indicate which vaccine(s) would like more information about? Please indicate which vaccine(s) you would like more information about? Please indicate which vaccine(s) you would like more information about? Please indicate which vaccine(s) you would like more information about? Please indicate which vaccine(s) you would like more information about? Please indicate which would like would li	10.	How many years has it been since	e your last TETANU.	S vaccine?						_yrs	P	
Please indicate which vaccine(s) you would like more information about? Please indicate which vaccine(s) you would like more information about?	11.	Patients 45 and under: Have you	u received the HPV (Human Papillon	mavirus) vaccino	e?			8		□	
Please indicate which vaccine(s) you would like more information about? Please indicate which vaccine(s) you would like more information about?	12	Patients aged 11 to 22: Have you	u received a menine	útic vaccine?					6	п	п	
Hepatitis A	12.				shout?							
Sy my signature below, I consent to the administration of the vaccine(s) by a pharmacist or a supervised student pharmacist or technician, where permitted by law or state/feder guidance, employed by Contoso Companies or one of its affiliated pharmacies and to be contacted at the number provided above regarding other immunizations for which I a law or eligible to receive. I also release Contoso Companies and its subsidiaries, affiliated at the number provided above regarding other immunizations for which I a law or eligible to receive. I also release Contoso Companies and its subsidiaries, affiliates, officers, directors, employees, and agents from all liability, including acts of omissis or commission, resulting or arising from my receipt of this vaccination. I understand that: 1) I have voluntarily chosen to receive the vaccination and understand that I am obligate op pay for all products and services received, if applicable. 2) I may be responsible for payment after the date of service if the product or service is billed to my medical benefit. 3 m of legal age and authorized to execute this consent form or I am the parent/guardian of the minor patient. 4) I will immediately alent the pharmacist of amy medical condition which may adversely affect my personal health or effectiveness of the vaccine. 5) I have been counseled about potential side effects after vaccination, when they may occur, any when and where I should seek treatment. I am responsible for following up with my physician at my expense if I experience any side effects. 6) I should remain in the area for I minutes after the vaccination for observation. 7) I have read on one, the Vaccine Information Statement(s) ("Wis") or Emergency Use Authorization ("EUA") provide or the vaccine(s) to be administered. I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction. I understand the benefits and ris of the vaccine(s), 8) I have been offered and/or provided a copy of the company's Notice of Privacy Practices in	13.	200				☐ Travel Vaccin	nes 🗆 (Other:				
For Pharmacy Use Only Vaccine Name Lot # Expiration Date Manufacturer Dose [ml] Dose # Route Site (circle) VIS/EUA Publication Date R / L Deltoid R / L Deltoid R / L ignature of RPh: Initials of Administrator: Administration Date: NPP Offered: □	By my signature below, I consent to the administration of the vaccine(s) by a pharmacist or a supervised student pharmacist or technician, where permitted by law or state/federaguidance, employed by Contoso Companies or one of its affiliated pharmacies and to be contacted at the number provided above regarding other immunizations for which I are due or eligible to receive. I also release Contoso Companies and its subsidiaries, affiliates, officers, directors, employees, and agents from all liability, including acts of omission or commission, resulting or arising from my receipt of this vaccination. I understand that: 1) I have voluntarily chosen to receive the vaccination and understand that I am obligate to pay for all products and services received, if applicable. 2) I may be responsible for payment after the date of service if the product or service is billed to my medical benefit. 3) am of legal age and authorized to execute this consent form or I am the parent/guardian of the minor patient. 4) I will immediately alert the pharmacist of any medical condition which may adversely affect my personal health or effectiveness of the vaccine. 5) I have been counseled about potential side effects after vaccination, when they may occur, an when and where I should seek treatment. I am responsible for following up with my physician at my expense if I experience any side effects. 6) I should remain in the area for 1 minutes after the vaccination for observation. 7) I have read, or have had read to me, the Vaccine Information Statement(s) ("VIS") or Emergency Use Authorization ("EUA") provide for the vaccine(s) to be administered. I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction. I understand the benefits and risk for the vaccine(s). 8) I have been offered and/or provided a copy of the company's Notice of Privacy Practices in compliance with the Health Insurance Portability and Accountability and Accountability and Accountability and Accountability and Accountabilit											
Vaccine Name Lot # Expiration Date Manufacturer Dose {ml} Dose # Route Site (circle) VIS/EUA Publication Date R / L Deltoid R / L Deltoid R / L R / L R / L Initials of Administrator: Administration Date: NPP Offered: □	ignature	e of Patient or Parent/Guardian of	f Minor Patient				•					
Publication Date				For Pha	rmacy Use Onl	у						
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ID#:

	Υ	N					
COVID Screening Questionnaire							
DO YOU HAVE THE FOLLOWING?							
Fever, shortness of breath, sore throat, chills, congestion, runny nose, diarrhea,							
nausea, or vomiting.							
COVID Vaccine Screening Questions	Υ	N					
Have you received a dose of COVID-19 vaccine?	١,						
If yes which product and when?	\ V						
Manufacturer: Pfizer Date: 08/05							
	-						
Have you ever had an allergic reaction after receiving a COVID-19 vaccine?							
Have you received any other vaccinations in the past 14 days?							
Have you received passive antibody therapy (monoclonal antibodies or							
convalescent serum) as treatment for COVID-19 within the last 90 days?							
Have you ever had a serious reaction to polyethylene glycol (PEG) or polysorbate?							
Have you ever had a severe allergic reaction to any vaccine, injectable therapies,							
food, pet, venom, environmental allergies, or oral medications for which you were							
treated with epinephrine or EpiPen, or for which you had to go to the hospital?							
If yes, please list:							
Do you have a bleeding disorder, or do you take a blood thinner?							
Last 4 of SSN: /4/4							
(For Uninsured Patients) DL#:							
To the best of my ability, I have verified this patient meets current							
eligibility requirements. Staff Initials: F. P.							