COVID-19 Screening Questionnaire for Immunizations

Store #: _____ Rx #: _____

Last Name: _____ First Name: _____ Date of Birth: _____

Screening Questions:	**YES**	**NO**
1. In the past two weeks, have you tested positive for COVID-19 or are you currently being monitored for COVID -19?	☐	☐
2. In the past two weeks, have you had contact with someone who tested positive for COVID-19?	☐	☐
3. Do you currently or have you in the past 14 days, experienced the new onset of a fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, vomiting, or diarrhea?	☐	☐

- If patient answers yes to any of these questions, please inform them that they should not receive the vaccine at this time and instruct them to contact their primary care provider for next steps.
- If the patient's bodily temperature is 100°F or greater, they should not receive the vaccine at this time. Patient should be instructed to contact their primary care provide next steps.

**Attach form to standard consent form and store with immunization records*

Patient Temperature: _____ Date: _____

_____ _____

Administering Immunizer Name & Title

Administering Immunizer Signature

CVS pharmacy

Store # _____ Address _____

RX # _____ City, State, Zip _____ Telephone _____

Inactive Vaccine Consent and Administration Record

Patient Information:

Last Name _____ First Name _____ Date of Birth _____

Address _____ City, State, Zip _____ Phone _____

Primary Care Provider (PCP) Name _____ PCP Phone # _____

PCP Address _____ City, State, Zip _____ PCP Fax # _____

Screening Questions:

	YES	NO	DON'T KNOW
1. Are you sick today? (For example: a cold, fever or acute illness)	☐	☐	☐
2. Do you have allergies or reactions to any foods, medications, vaccines or latex? (For example: eggs, gelatin, neomycin, thimerosal, etc.) List _____	☐	☐	☐
3. Do you take anticoagulation medication? (For example: warfarin, Coumadin or other blood thinner)	☐	☐	☐
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g. diabetes), anemia or other blood disorder?	☐	☐	☐
5. For women: Are you pregnant or nursing? Could you become pregnant during the next month?	☐	☐	☐
6. **For Shingrix Only:** Do you have a weakened immune system or in past 3 months, taken medications that weaken it such as cortisone, prednisone, other steroids, anticancer drugs, or radiation treatments?	☐	☐	☐

CONSENT FOR SERVICES: I have been provided with the Vaccine Information Sheet(s) corresponding to the vaccine(s) that I am receiving. I have read or have had explained to me the information provided about the vaccine I am to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I request that the vaccine be given to me or to the person named above for whom I am authorized to make this request.

AUTHORIZATION TO REQUEST PAYMENT: I do hereby authorize CVS Pharmacy® ("CVS®") to release information and request payment. I certify that the information given by me in applying for payment under Medicare or Medicaid is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf.

DISCLOSURE OF RECORDS: I understand that CVS® may be required to or may voluntarily disclose my health information to the physician responsible for this protocol of specific health information of people vaccinated at CVS (if applicable), my Primary Care Physician (if I have one), my insurance plan, health systems and hospitals, and/or state or federal registries, for purposes of treatment, payment or other health care operations (such as administration or quality assurance). I also understand that CVS will use and disclose my health information as set forth in the CVS Notice of Privacy Practices (copy is available in-store, online or by requesting a paper copy from the pharmacy).

X _____ **Date:** _____

Signature of patient to receive vaccine or person authorized to make the request (parent/guardian)

Vaccine Administration Information:

Administration Date _____ Vaccine _____ Manufacturer _____

Lot # _____ Exp. Date _____ Route _____ Site _____

Volume (mL) _____ VIS Version Date _____ Date VIS Given to Pt _____

_____ _____

Administering Immunizer Name & Title Administering Immunizer Signature

Store Number | Address

Rx Number | City, State, Zip | Phone Number

Vaccine Consent and Administration Record

Patient Information:

Last Name | First Name | Date of Birth

Address | City, State, Zip | Phone Number

Primary Care Provider (PCP) | PCP Phone Number

PCP Address | City, State, Zip | PCP Fax Number

Check all vaccines interested in receiving:

◯ Flu ◯ Shingles (Shingrix) ◯ Tdap (Boostrix) ◯ Pneumonia Prevnar 13 ◯ Pneumonia Pneumovax 23

Screening Questions:

Are you sick today? (For example: a cold, fever or acute illness)	◯ Yes	◯ No	◯ Don't Know
Do you have allergies or reactions to any foods, medications, vaccines or latex? (For example: eggs, gelatin, neomycin, thimerosal, etc.) List:	◯ Yes	◯ No	◯ Don't Know
Do you take anticoagulation medication? (For example: warfarin, Coumadin or other blood thinner)	◯ Yes	◯ No	◯ Don't Know
Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g. diabetes), anemia or other blood disorder?	◯ Yes	◯ No	◯ Don't Know
For women: Are you pregnant or nursing? Could you become pregnant during the next month?	◯ Yes	◯ No	◯ Don't Know

If someone else manages health decisions on your behalf, please provide the following:

Caregiver or Financially Responsible Party Name

Relationship | Phone Number

Address | City, State, Zip

Signature _____ **Date** _____

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DISCLOSURE OF RECORDS: I understand that CVS may be required to or may voluntarily disclose my health information to the physician responsible for the provision of specific health information of people vaccinated at CVS (if applicable), my Primary Care Physician (if I have one), my insurance plan, health systems and hospitals, and/or state or federal immunization registries for purposes of treatment, payment or other health care operations (such as administration or quality assurance). I also understand that CVS will use or disclose my health information as set forth in the CVS Notice of Privacy Practices (copy is available in-store, online or by requesting a paper copy from the pharmacist).

VACCINE ADMINISTRATION INFORMATION (FOR PHARMACIST USE ONLY):

Administration Date	Administration Date	Administration Date	Administration Date
Vaccine	Vaccine	Vaccine	Vaccine
Manufacturer	Manufacturer	Manufacturer	Manufacturer
Lot Number	Lot Number	Lot Number	Lot Number
Expiration Date	Expiration Date	Expiration Date	Expiration Date
Route	Route	Route	Route
Site	Site	Site	Site
Volume (mL)	Volume (mL)	Volume (mL)	Volume (mL)
VIS Version Date	VIS Version Date	VIS Version Date	VIS Version Date
Date VIS Given to Pt	Date VIS Given to Pt	Date VIS Given to Pt	Date VIS Given to Pt
Administering Immunizer Name	**Administering Immunizer Name**	**Administering Immunizer Name**	**Administering Immunizer Name**
Administering Immunizer Title	**Administering Immunizer Title**	**Administering Immunizer Title**	**Administering Immunizer Title**
Administering Immunizer Signature	**Administering Immunizer Signature**	**Administering Immunizer Signature**	**Administering Immunizer Signature**