Immunization Pre-Screening

Please check requested vaccine(s): ❍ **COVID-19 Vaccine Dose One** ❍ **COVID-19 Vaccine Dose Two**
❍ **COVID-19 Vaccine Dose Three for Immunocompromised** ❍ **COVID-19 Vaccine Booster**
❍ **Flu** ❍ **Pneumonia** ❍ **Shingles** ❍ **Pertussis** ❍ **Other** ___________________________

Previous Pharmacy Customers: Please fill out the information shaded in **GRAY**. **New Pharmacy Customers:** Please fill out **ALL** of the information.

Patient Name (Printed)	DOB	Age	Sex	Date

Address	City	State	Zip Code	Phone

Allergies	Weight

Insurance ID	Insurance BIN	Insurance PCN	Insurance GRP

Emergency Contact Name	Emergency Contact Phone

New York only: I opt in to reporting information to the immunization registry in my state. ❍ N/A ❍ Yes ❍ No
Massachusetts only: I was informed that my vaccination information will be reported to the immunization registry in my state. ❍ N/A ❍ Yes ❍ No

Screening Questionnaire *(Please answer all questions.)*

1. Are you feeling sick and/or have a fever today? ❍ Yes ❍ No

2. Have you had any of the following symptoms in the last 14 days?
   ❍ Fever ❍ Cough ❍ Shortness of Breath ❍ Fatigue ❍ Muscle Pains ❍ Headache ❍ New Loss of Taste or Smell ❍ Sore Throat
   ❍ Congestion or Runny Nose ❍ Nausea or Vomiting ❍ Diarrhea ❍ None

3. In the last 14 days, have you had a COVID-19 test or been told by a healthcare provider or health department to isolate at home due to COVID-19 infection? ❍ Yes ❍ No

4. In the last 14 days, have been told by a healthcare provider or health department to quarantine at home due to COVID-19 exposure or travel? ❍ Yes ❍ No

5. Have you been treated with antibody therapy or convalescent plasma for COVID-19 in the past 90 days (3 months)?
   If yes, when did you receive the last dose? Date: ______________________ ❍ Yes ❍ No

6. Have you ever had an immediate allergic reaction, such as hives, facial swelling, difficulty breathing or anaphylaxis, to any vaccine or shot or to any component of the COVID-19 vaccine, such as polyethylene glycol (PEG) or polysorbate? ❍ Yes ❍ No

7. Are you pregnant, nursing, or plan to become pregnant within 4 weeks of vaccination? ❍ Yes ❍ No

8. Do you have cancer, leukemia, HIV/AIDS, a history of autoimmune disease or any other condition that weakens the immune system? ❍ Yes ❍ No

9. Do you take any medications that affect your immune system, such as cortisone, prednisone or other steroids, anticancer drugs, or have you had any radiation treatments? ❍ Yes ❍ No

10. Do you have a bleeding disorder or are you taking a blood thinner? ❍ Yes ❍ No

11. Have you received a previous dose of COVID-19 vaccine? *If yes, what type and when?* ❍ Yes ❍ No
    Vaccine Type: ______________________________ Date: ______________
    Vaccine Type Dose 2 (if applicable): ______________________________ Date: ______________

12. Are you requesting your third COVID-19 vaccine for the immunocompromised? *If yes, fill out "COVID-19 Vaccination Third Dose Consent" form.* ❍ Yes ❍ No

13. Have you ever had a serious reaction after receiving a vaccine? ❍ Yes ❍ No

14. Have you received any vaccines in the past 4 weeks? ❍ Yes ❍ No

15. Do you have any allergies to medications, food, thimerosal, or vaccine ingredient? ❍ Yes ❍ No

16. Do you have a long-term health problem such as heart disease, lung disease, asthma, kidney disease, diabetes, anemia, or blood disorder? ❍ Yes ❍ No

17. Do you have cancer, leukemia, AIDS, or any other immune system problem? ❍ Yes ❍ No

18. Have you had a seizure, brain, or other nervous system problem such as Guillain-Barre syndrome? ❍ Yes ❍ No

19. During the past year have you received a transfusion of blood or blood products or been given immune (gamma) globulin? ❍ Yes ❍ No

Immunization Consent

I have received the Vaccine Information Statement(s) and the content was explained to me before vaccine administration. I understand that if this vaccine requires two doses, two doses of this vaccine will need to be administered in order for it to be effective. I have had a chance to ask questions which were answered to my satisfaction and I understand the benefits and risks of the vaccination(s). I request that the vaccination(s) be given to me (or the person named below for whom I am authorized to make this request). The Golub Corporation may use and disclose my personal and health information for treatment, to receive payment for the care provided, and for other health care operations. Health care operations generally include those activities performed to improve the quality of care. I acknowledge that I acknowledge I have been offered a detailed copy of the NOTICE OF PRIVACY AND CONFIDENTIAL PRACTICES to help me better understand The Golub Corporation's policies in regards the use of my personal health information. I agree to remain in the general area for at least 15-30 minutes after being vaccinated. I certify that information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare/Medicaid or other private insurance benefits be made on my behalf to The Golub Corporation. I authorize The Golub Corporation to bill my insurance carrier directly for services provided on my behalf. I authorize payment for any services provided to me by The Golub Corporation to be paid directly to The Golub Corporation.

For COVID-19 Vaccine: The FDA has approved the Pfizer-BioNTech product COMIRNATY. The FDA has made other versions of the COVID-19 vaccine available under an emergency use authorization (EUA). The EUA is used when circumstances exist to justify the emergency use of drugs and biologic products during an emergency, such as the COVID-19 pandemic. This vaccine has not completed the same type of review as an FDA-approved or cleared product. However, the FDA's decision to make the vaccine available under an EUA is based on the existence of a public health emergency and the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks. In addition, if I have received two doses of vaccine but if I have a weakened immune system (immunocompromised) I understand that an additional dose(s) of vaccine is recommended.

For MA residents only: I attest under pain and penalty of perjury that I am a member of one of the groups that is currently eligible for vaccination per the MA COVID Vaccination Prioritization; current eligible groups can be found at mass.gov here. Individuals who live, work, or study in Massachusetts are eligible for vaccination. I have reviewed the currently eligible groups and attest that I am a member.

Name of Recipient (Printed)	Signature of Recipient or Guardian	Date

Primary Care Provider Name	Primary Care Provider City	❍ I do not have a Primary Care Provider

Ethnicity: ❍ Declined ❍ Hispanic ❍ Non-Hispanic ❍ Unknown

Race: ❍ Native American or Alaskan ❍ Asian ❍ African American or Black ❍ Native Hawaiian or Pacific Islander ❍ White ❍ Declined ❍ Other or Multiracial

Immunizer to verify appropriate vaccine type and dose for patient age and vaccine history. Previous vaccination history was verified by checking state immunization registry (if available) and full one year of Enterprise history. ❍ Yes ❍ No

COVID-19 Vaccine Type and Dosing
Janssen Dose One or Booster 0.5ml, for those 18+
Moderna Dose One, Two, or Third Dose for Immunocompromised 0.5ml, for those 18+
Moderna Booster Dose 0.25ml, for those 18+
Pfizer Dose One, Two, Third Dose for Immunocompromised, 0.3ml, for those 12+
Pfizer Booster Dose 0.3ml for those 16+
Pfizer Pediatric Dose One or Two 0.2ml, for those 5-11

COVID-19 Vaccine

Manufacturer: ❍ Moderna ❍ Pfizer ❍ Janssen

Vaccine Type: ❍ 1st Dose ❍ 2nd Dose ❍ 3rd Dose for Immunocompromised ❍ Booster Dose

Dosage:

Administration: ❍ IM: ❍ Left Deltoid ❍ Right Deltoid

Lot Number:

Expiration Date:

If Third Dose for Immunocompromised or Booster:
Vaccine Dose One Type: ____________________
Vaccine Dose One Date: __________
Vaccine Dose Two Type: ____________________
Vaccine Dose Two Date: __________

For Third Dose for Immunocompromised: Has it been 28 days since mRNA primary series was completed? ❍ Yes ❍ No ❍ N/A
If no, do not administer.

For Booster Doses: Has it been 6 months since primary mRNA series or 2 months since Janssen dose was administered? ❍ Yes ❍ No
If no, do not administer

Next Immunization Due:
❍ 28 Days ❍ 21 Days ❍ Series Complete ❍ N/A ❍ Other

Recommended Observation Time: ❍ 15 minutes ❍ 30 minutes

Vaccine Information Statement (VIS) Date:

Date VIS Given to Patient:

Address of Immunization:

Immunizer Name (Printed):

Immunizer Signature:

All Other Vaccines

1) Manufacturer:

Vaccine Name:

Dosage:

Administration: ❍ IM: ❍ Left Deltoid ❍ Right Deltoid
❍ SQ: ❍ Left Arm O Right Arm

Lot Number:

Expiration Date:

Next Immunization Due: ❍ Next Year ❍ N/A ❍ Other

Series Complete: ❍ Yes ❍ No

Recommended Observation Time: ❍ 15 minutes ❍ 30 minutes

Vaccine Information Statement (VIS) Date:

Date VIS Given to Patient:

2) Manufacturer:

Vaccine Name:

Dosage:

Administration: ❍ IM: ❍ Left Deltoid ❍ Right Deltoid
❍ SQ: ❍ Left Arm O Right Arm

Lot Number:

Expiration Date:

Next Immunization Due: ❍ Next Year ❍ N/A ❍ Other

Series Complete: ❍ Yes ❍ No

Recommended Observation Time: ❍ 15 minutes ❍ 30 minutes

Vaccine Information Statement (VIS) Date:

Date VIS Given to Patient:

Address of Immunization:

Immunizer Name (Printed):

Immunizer Signature:

Date Faxed to Primary Care Provider:
____________________ ❍ N/A