

# SCREENING QUESTIONNAIRE FOR IMMUNIZATIONS



Patient Name \_\_\_\_\_ Patient ID \_\_\_\_\_  
 Patient Address \_\_\_\_\_ Vacc/Manuf: \_\_\_\_\_  
 City, State, ZIP \_\_\_\_\_ Exp \_\_\_\_\_  
 Patient Phone # \_\_\_\_\_ Pharm \_\_\_\_\_  
 Patient Date of Birth \_\_\_\_\_ Site \_\_\_\_\_ Dose \_\_\_\_\_  
 Patient Primary Care Physician \_\_\_\_\_

**For Patients:** The following questions will help us determine which vaccines may be given today.  
 If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't Know
Are you sick today? (fever)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have allergies to medications, food, or any vaccine? (chicken eggs, egg products, thimerosal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a serious reaction after receiving a vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a long-term health problem with heart disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have cancer, leukemia, AIDS, or any other immune-system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had x-ray treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a seizure, or brain or nervous-system problem? (Guillain-Barre)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
For women: Are you pregnant, or is there a chance that you may become pregnant during the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you received any vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please describe any chronic health conditions or other information you feel we should know:

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### Authorized Consent and Waiver

I, the undersigned, acknowledge that I voluntarily consent to the general screening and/or immunizations that I have selected on this form(s). I represent and warrant to Fred's that I am not on any medications (prescriptions or otherwise) and I do not have any allergies, health condition, or symptoms which would prevent me from obtaining the services on this form(s). I recognize that this general screening may not be completely accurate and is not a substitute for a physical or other services provided by a licensed physician. I have been strongly urged to discuss the results with a physician. To the fullest extent allowed by law, I, the undersigned, hereby release Fred's (and its parents, affiliates, agents, suppliers, employees, officers, and directors) from and against any and all liability, connection therewith. I (on behalf of myself, my spouse, dependents, successors, and assigns) hereby agree to indemnify, defend, reimburse and hold harmless Fred's (and its parent, affiliates, agents, suppliers, employees, officers, and directors) from and against any and all costs (including court costs and attorney's fees), damages, suits, actions, demands, and liability associated with or arising from (1) any misstatements or omissions on any form I provided to Fred's and/or (2) my receipt of any testing, screening, and/or immunization from Fred's.

All information on this form is correct and complete to the best of my knowledge. I have been given a Vaccine Information Sheet (VIS) and understand the risks and benefits of vaccinations.

I consent to receive the following vaccine(s): \_\_\_\_\_

I agree to the foregoing,

Name \_\_\_\_\_ Date \_\_\_\_\_