

ROCK HILL PHARMACY
UNIVERSAL IMMUNIZATION SCREENING & CONSENT FORM
253 Rock Hill Drive, Rock Hill, NY 12775 | 845-791-1515

Last Name: _____	First Name: _____
Address: _____	City / State / ZIP: _____
DOB: _____ Age: _____ Sex: _____	Phone: _____ Today's Date: _____
Primary Care Practitioner: _____	PCP Phone: _____ PCP City/State: _____

VACCINE(S) REQUESTED / RECOMMENDED TODAY

- | | | | |
|------------------------------------|------------------------------------|---------------------------------------|---------------------------------------|
| ☐ Influenza | ☐ COVID-19 | ☐ Pneumococcal | ☐ Shingrix |
| ☐ Hep A | ☐ Hep B | ☐ Hep A/B | ☐ HPV |
| ☐ MMR | ☐ Varicella | ☐ MenACWY | ☐ MenB |
| ☐ Tdap | ☐ Td | ☐ RSV | ☐ JYNNEOS/Mpox |

Other vaccine: _____

Instructions: Answer every applicable question. A YES response requires pharmacist review and does not automatically prevent vaccination.

UNIVERSAL PRECAUTIONS & CONTRAINDICATION SCREENING

#	SCREENING QUESTION	YES	NO	N/A
1	Are you moderately or severely ill today, with or without fever?	☐	☐	☐
2	Have you ever had a severe allergic reaction (anaphylaxis), hives, swelling, wheezing, or breathing difficulty after a vaccine, injectable medicine, or within 4 hours of a prior vaccine?	☐	☐	☐
3	Do you have a serious allergy to a vaccine component or other substance, including latex, gelatin, yeast, egg/chicken protein, PEG, polysorbate, antibiotics, medication, food, venom, or environmental allergen?	☐	☐	☐
4	Have you ever fainted, had extreme dizziness, seizure, or another serious reaction during or after an injection/vaccination?	☐	☐	☐
5	Have you ever had Guillain-Barre syndrome (GBS), especially within 6 weeks after influenza or a tetanus-containing vaccine?	☐	☐	☐
6	Do you have a bleeding/platelet disorder, thrombocytopenia, or take an anticoagulant/blood thinner or aspirin that may affect injection?	☐	☐	☐
7	Do you have a weakened immune system (HIV, cancer, transplant) or take chemotherapy, radiation, biologic/immune-modifying drugs, anti-cancer drugs, or prolonged/high-dose steroids?	☐	☐	☐
8	Are you pregnant, possibly pregnant, trying to become pregnant, or breastfeeding? If pregnant, gestational age: _____ weeks.	☐	☐	☐
9	Have you received any vaccine in the past 4 weeks? If yes, vaccine/date: _____	☐	☐	☐
10	Have you received blood, plasma, transfusion, immune globulin, antibody-containing products, or monoclonal antibody treatment during the past year?	☐	☐	☐
11	Are you taking antiviral medicine, including acyclovir/valacyclovir/famciclovir or influenza antivirals?	☐	☐	☐
12	Have you ever had myocarditis, pericarditis, MIS-C/MIS-A, encephalopathy/prolonged seizure/coma after pertussis vaccine, or a severe Arthus-type reaction after tetanus/diphtheria vaccine?	☐	☐	☐
13	Do you have a long-term condition affecting vaccine recommendations (heart/lung disease, asthma, diabetes, kidney/liver disease, blood disorder, asplenia, cochlear implant, CSF leak, complement disorder/inhibitor, dialysis, or other)?	☐	☐	☐
14	Have you previously received any vaccine being considered today? If yes, list vaccine/product and approximate date below.	☐	☐	☐

Explain YES answers, allergies, conditions, prior vaccines/reactions and dates:

VACCINE-SPECIFIC PHARMACIST REVIEW - COMPLETE WHEN APPLICABLE

Live: MMR / Varicella / LAIV	Pregnancy; severe immunosuppression; live vaccine in prior 4 weeks; recent immune globulin/blood product; recent antivirals; LAIV salicylate/influenza antiviral use.
COVID-19	Prior myocarditis/pericarditis or MIS-C/MIS-A; severe reaction to prior dose/component (including PEG); recent infection/date.
Tdap / Td	Wound/burn/puncture/bite; prior pertussis encephalopathy; GBS within 6 weeks; prior Arthus reaction; last tetanus dose/date.
RSV	Prior RSV vaccine/product/date; pregnancy/gestational age; prior GBS/serious neurologic reaction; current age/risk/pregnancy indication.
Pneumococcal	Prior PCV/PPSV product/date(s); risk conditions and required interval.
HepA / HepB / Twinrix	Prior series/dates; dialysis/special HepB dosing; product-component/yeast allergy.
MenACWY / MenB	Prior product/dates; asplenia, complement deficiency/inhibitor, travel, outbreak, occupational or booster indication.
HPV / Shingrix / JYNNEOS	Prior series/product/date; pregnancy where relevant; current shingles; JYNNEOS/ACAM2000 history and current risk/exposure indication.

PHARMACIST CLINICAL REVIEW

- | | |
|--|--|
| ☐ Age/product eligibility and NY pharmacist scope confirmed. | ☐ NYSIIS/history reviewed as applicable. |
| ☐ Contraindications/precautions reviewed for each selected vaccine. | ☐ Product/formulation, dose, route, site and interval verified. |
| ☐ Proceed - no contraindication. | ☐ Precaution reviewed; vaccination appropriate. |
| ☐ Defer/refer - reason: _____ | |

Clinical notes: _____

ROCK HILL PHARMACY - CONSENT & PHARMACY DOCUMENTATION

PATIENT INFORMATION & INFORMED CONSENT

I certify that the information on this form is accurate to the best of my knowledge. Before vaccination, I have been informed **orally and in writing** of potential side effects and adverse reactions. I received the current applicable Vaccine Information Statement (VIS), FDA patient information/fact sheet, or other required written information, and written instructions regarding what to do if an adverse reaction occurs. I had an opportunity to ask questions. I understand the expected benefits, material risks and alternatives and voluntarily consent to administration of the vaccine(s) documented below by an authorized Rock Hill Pharmacy immunizer. I understand emergency medical treatment may be initiated if a serious reaction occurs.

NYSIIS / PRIMARY CARE COMMUNICATION

Under age 19: required reporting to NYSIIS applies for vaccinations administered outside NYC. **Age 19+:**

- ☐ YES, I consent to identifiable adult NYSIIS reporting/sharing. ☐ NO, I do not consent to identifiable adult NYSIIS reporting.
- ☐ I consent to communication of vaccine administration information to my primary health care practitioner as permitted/required by law. ☐ No PCP / unable to identify.

HIPAA / PAYMENT AUTHORIZATION

I acknowledge that Rock Hill Pharmacy may use and disclose my protected health information for treatment, payment, health care operations, and disclosures otherwise permitted or required by law, consistent with its Notice of Privacy Practices. I authorize submission of claims and release of information reasonably necessary to obtain payment from my insurer or government health program for the vaccine/service provided.

MEDICARE BENEFICIARIES - IF APPLICABLE

I request that payment of authorized Medicare benefits be made to me or on my behalf to Rock Hill Pharmacy for covered services/items furnished to me. I authorize release of information to CMS and its agents as needed to determine benefits or payment. I understand I remain responsible for applicable deductible, coinsurance, or non-covered amounts, subject to law and coverage.

PATIENT / LEGAL REPRESENTATIVE SIGNATURE

Patient / Legal Representative Signature: _____	Date: _____
Print Name / Relationship: _____	Phone: _____

PHARMACY USE ONLY - VACCINE ADMINISTRATION

Vaccine / Product	Manufacturer	Lot #	Exp.	Dose	Route	Site	Time

VIS Date:	_____	NYSIIS:	Reported/Queued _____ Adult Declined _____
PCP:	Sent/Queued _____ N/A _____	Certificate Provided:	Yes _____
Immediate Reaction:	None _____ Yes _____	Reaction Notes:	_____
Immunizer Name:	_____	Date:	_____
Immunizer Signature:	_____	Time Completed:	_____

Pharmacy Label

PHARMACY NOTES