12 St. Paul Drive, Ste. 105
Chambersburg, PA 17201
(717) 217-6790
www.NorlandRx.com

Be healthy, stay healthy.

Immunization Questionnaire & Consent Form

Patient Information: (Patient Please Complete)

Patient Name: _____ Date of Birth: _____ Age: _____ Gender: _____

Phone: _____ Email Address: _____

Address: _____ City/State/Zip: _____

Emergency Contact: _____ Emergency Phone: _____

Primary Doctor: _____ Drug Allergies: _____

Name EXACTLY as shown on Medicare or Insurance card: _____

Medicare or Insurance ID #: _____

RxGroup: _____ RxBIN: _____ RxPCN: _____

The following questions will help us determine which vaccine(s) may be given today. If a questions is not clear, please ask your Norland Avenue pharmacist to explain it.

All Vaccines	**Yes**	**No**	**Unsure**
Are you sick today or do you have a fever?			
Do you have allergies to eggs, latex, or any vaccine component (neomycin, formaldehyde, gentamicin, thimerosal, bovine protein, phenol, polymixin, gelatin, baker's yeast, or yeast)?			
Have you ever had a serious reaction after receiving a vaccination?			
Have you received any vaccinations in the past four weeks?			
Do you have a neurological disorder such as seizures or other disorders that affect the brain or have had a disorder that resulted from a vaccine (i.e. Guillain-Barre Syndrome)?			
For women: Are you pregnant, becoming pregnant in the next three months, or are you nursing?			
For patients over 50 OR those with a chronic condition such as asthma, COPD, or diabetes OR those that smoke: Have you received the Pneumococcal or "pneumonia" vaccine?			
Are you up-to-date on your tetanus and pneumonia vaccinations?			
Have you had any form of prednisone (orally or cortisone injection) in the last two to four weeks?			

I authorize the release of any medical or other information with respect to this vaccine to my healthcare providers, Medicare, Medicaid, or other third party payer as needed and request payment of authorized benefits to be made on my behalf to Norland Avenue Pharmacy.

- I acknowledge that if my insurance does not cover the cost of administering the vaccine at the pharmacy, then payment must be made at the time of the administration of the vaccine.
- I acknowledge that my vaccination record may be shared with federal or state agencies for registry reporting.
- I acknowledge that the pharmacist recommends that vaccinated patients should remain in the waiting area, after the administration of the immunization, for 20 minutes.
- I have read, or have had read to me, the Vaccination Information Sheet (VIS) regarding the vaccine(s). I have had the opportunity to ask questions that were answered to my satisfaction and understand the benefits and risks of the vaccine(s). I fully release and discharge Norland Avenue Pharmacy, affiliates, and their employees from any liability for illness, injury, loss, or damage which may result there from.
- I acknowledge that received vaccinations will be forwarded to my doctor.

Patient Signature: _____ **Date:** _____

Pharmacy Use Only **Administration Site(s): _____**

Immunization	VIS Date	Lot #	Expiration Date	Dose
Havrix (Hep A)				
Vaqta (Hep A)				
Engerix-B (Hep B)				
Recombivax HB (Hep B)				
Shingrix (Shingles)				
Influenza: _____				
Pneumovax 23 (Pneumococcal)				
Prevnar 13 (Pneumococcal)				
Adacel (Tdap)				
Boostrix (Tdap)				
Other:				

Place Rx Label Here

Place Rx Label Here

Signature of pharmacist who administered vaccine(s): _____ Date: _____