# Immunization Screening, Consent, and Physician Fax Form

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_\_\_\_

Insurance Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GRP#: \_\_\_\_\_\_\_\_\_\_\_\_

MALE / FEMALE Vaccination Requested: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ VIS Date: \_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## COVID-19 Vaccine Eligibility and Screening (Pennsylvania – Effective 9/9/2025)

**COVID-19 Vaccine Screening Questions**

1. Are you 65 years of age or older? Yes / No

2. If under 65, do you have one or more underlying health conditions (such as asthma, obesity, cancer, smoking history, or other conditions that increase risk for severe COVID-19)? Yes / No

3. (For children) Has a healthcare provider evaluated you and determined that you are eligible to receive the COVID-19 vaccine? Yes / No

4. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to a COVID-19 vaccine or any of its components (such as polyethylene glycol or polysorbate)? Yes / No

5. Have you ever experienced myocarditis or pericarditis after receiving an mRNA COVID-19 vaccine? Yes / No

6. Have you tested positive for COVID-19 within the past 3 months? Yes / No

7. Are you currently feeling ill today (fever, cough, fatigue, sore throat, or other symptoms)? Yes / No

8. Have you received any other vaccine (including mpox vaccine) in the past 4 weeks? Yes / No

I attest that my answers above are true and accurate, and that I meet the current eligibility requirements for COVID-19 vaccination in Pennsylvania.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## General Immunization Screening Questions

1. Are you sick today? Yes / No

2. Do you have allergies to medications, food, or any vaccine? Yes / No

3. Have you ever had a serious reaction after receiving a vaccine? Yes / No

4. Do you have cancer, leukemia, AIDS, or any immune system problems? Yes / No

5. Do you have a seizure, brain, or other nervous system problem? Yes / No

6. Have you had a transfusion of blood or blood products, or received immune (gamma) globulin in the past year? Yes / No

7. For women: Are you pregnant or is there a chance you could become pregnant in the next month? Yes / No

8. Have you had any vaccines in the past 4 weeks? Yes / No

9. Do you take cortisone, prednisone, other steroids, anticancer drugs, or have you had any radiation treatments recently? Yes / No

## Consent and Authorization

I authorize the pharmacist to send copies of my vaccine records to my primary care provider, protocol physician, Medicare, Medicaid, or any other third-party payer as needed and request payment of authorized benefits.

I have read or had read to me the VIS (Vaccine Information Sheet) regarding the vaccine I requested and had the opportunity to ask questions prior to administration.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Vaccine Administration Record

Vaccine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Lot#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exp Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Site Administered: Left Arm / Right Arm

Administered By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Lic#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_