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1. In You sick today? 2. Do you have any allergies to medications, food or vaccines? If yes, please list: 3. Have you sere had a serious reaction or fainted after receiving a vaccination (e.g. Guillain-Barré Syndrome)? 4. For vovemen. Are you pregnant or are you considering becoming pregnant in the next month? 5. Shake well as the stapp to you. 6. Please indicated a condition(s) or take medication(s) that weaken pour immune system? (e.g. cancer, leukemia, HIV, active disorder or a brain disorder (tapp only) are medical condition(s) or take medication(s) that weaken pour immune system? (e.g. cancer, leukemia, HIV, active shingles, or al steroids, anticancer or antivival downwards which vaccine(s) you would like more information about 72 Hepath's A. MINE (Neases), MINES, Research, MINES, and the steroids, anticancer or antivival downwards which vaccine(s) you would like an assessment done of potential vaccination gaps or needs 6. Please indicated a present of the steroid of the stero			☐ Caucasian ☐ Two or More	Other	11011						
1. Nev you sick today? 2. Doyou have any allergies to medications, food or vaccines? If yes, please list: 3. Have you ever had a serious reaction or fainted after receiving a vaccination (e.g. Guillain-Barré Syndrome)? 4. For women: Are you pregnant or are you considering becoming pregnant in the next month? 5. Check all that apply to you: 6. Please Indicated an Assistance or a brain disorder (tabp only) 7. Check all that papit you you: 7. Please Indicated which vaccine(s) you would like mone information about? 8. Please Indicated which vaccine(s) you would like mone information about? 9. Please Indicated which vaccine(s) you would like mone information about? 9. Please Indicated which vaccine(s) you would like mone information about? 9. Please Indicated which vaccine(s) you would like mone information about? 9. Please Indicated which vaccine(s) you would like mone information about? 9. Please Indicated which vaccine(s) you would like mone information about? 9. Please Indicated which vaccine(s) you would like mone information about? 9. Please Indicated which vaccine(s) you would like mone information about? 9. Please Indicated which vaccine(s) you would like mone information about? 9. Please Indicated which vaccine(s) you would like mone information about? 9. Please Indicated which vaccine(s) you received a present present that the please you received a present present between the present pr	reening Questions					Water Street		640909		Vas	N
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Please indicate which vaccine(s) you would like on en information about? Hepatists A. MMR (Neases, Mumps, Rubells) Travel Vaccines Childhood Vacci										0	-
New you never received a PNEUMONIA vaccine? If yes, when and what kind(s)?	Please indicate	al condition(s) or take	e medication(s) that weaken your i I would like more information abo	mmune system? (e.g. out? Hepatitis A	cancer, leukemia, HIV, ac MMR (Measles, Mumps,	tive shingles, or Rubella) 🗖 Tr	ral steroids	, anticano	er or ant	iviral Vaccin	drug: nes
7. Have you ever received a PNEUMONIA vaccine? If yes, when and what kind(s)? 8. Patients 50 and older of immunocompromised: Have you ever received the SHINGLES vaccine? If so, what date(s): 9. Patients 19 to 59 years old: Have you received a hepatitis 8 vaccine series? 10. Patients ander 46: Have you received the HPV (Human Papillomavirus) vaccine? 11. Patients aged 11 to 23: Have you received a meningitis vaccine? 12. How many years has it been since your lest TETANUS vaccine? 13. Have you received any vaccination in the past 4 weeks? If yes, please list: 14. During the past year, have you received a blood translusion, by bour thyrnus such as an synsystemia gravity. By the your received any vaccination in the past 4 weeks? If yes, please list: 15. Have you have you were received a blood translusion, by bour thyrnus such as an synsystemia gravity. Discogreg syndrome, or thyrnoma? (yellow fever only) 16. Are you currently taking any antiblocitic or antimalarial medications? (yeal typholid only) 17. Do you that we a history of thrombocytopenia or thrombocytopenia or thrombocytopenia purpura? (MMR* Ill only) 18. For age under 18: Are you taking aspirin or an aspirin containing medication? (intransal flu only) 19. Consent: Please read and sign. 19. Or you that we have particulated in the past of the working of the properties of the working of the working of the properties of the working of the work			Onsure: would like a	n assessment done of	potential vaccination gap	os or needs			Vac	Ma	lines
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VEX.CLINES ONLY (chickenpox, cholera, intranasal fitu, MMR* II, rotavirus, oral typhoid, and yellow fever) Ves N Alave you received any vaccination in the past 4 weeks? If yes, please list: 4.4 During the past year, have you received a blood transfusion, blood products, been given a medicine called immune (gamma) globulin, or had radiation therapy? 4.5 Have you had your thymus gland removed or problems with your thymus such as myasthenia gravis, DiGeorge syndrome, or thymoma? (yellow fever only) 4.6 Are you currently taking any antibiotics or antimalarial medications? (roral typhoid only) 5.6 Are you currently taking any antibiotics or antimalarial medications? (roral typhoid only) 5.7 Do you have a history of thrombocytopenia or thrombocytopenia purpura? (MMR* II only) 5.8 For age under 18: Are you taking aspirin or an aspirin containing medication? (intranasal flu only) 5.9 For age under 18: Are you taking aspirin or an aspirin containing medication? (intranasal flu only) 5.9 For age under 18: Are you taking aspirin or an aspirin or an aspirin provided above regarding other immulations for which I am due or eligible to receive. The above information is true and complexed or contained at the number provided above regarding other immulations for which I am due or eligible to receive. The above information is true and combined to the contained at the number provided above regarding other immulations for which I am due or eligible to receive. The above information is true and combined to the contained at the number provided above regarding other immulations or which I am due or eligible to receive. The above information is true and contained with the contained at the number provided above regarding other immulations or which it am due or eligible to receive. The above information is true and contained the contained at the number receive in the minute and the contained and its submitted and the contained and the number and the contained in the minute and the contained and the contained and the contained									- 		
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wy signature below, I consent to the administration of the vaccine(s) by a pharmacist or a supervised student pharmacist or technician, or other authorized person, where permitted by law or state/federal guidance, employed or contributed by the pharmacist or the contributed of the vaccination of the vaccine (s) by a pharmacist or a supervised student pharmacist or technician, or other authorized person, where permitted by law or state/federal guidance, employed or contributed by the pharmacist or the contributed by the c	7. Do you have a h										0
ny signature below, I consent to the administration of the vaccine(s) by a pharmacter or a supervised student pharmacist or to recincion, or other authorized person, where permitted by law or statz/federal guidance, employed or confidence and the contracted at the number provided above regarding other immunizations for which I am due or eligible to receive. The above information is true and correct. I attest I billity oriteria for the vaccination (if any); if I am the parent/guardian of the minor patient, lattest the minor patient meets eligibility oriteria for the vaccination (if any); if I am the parent/guardian of the minor patient, lattest the minor patient meets eligibility oriteria for the vaccination (if any); if I am the parent/guardian or the minor patient, each receiving a flu vaccination and it is prior to September 1°, I am either a parent signific on behalf of my child neceiving the vaccine, gregant in my third trimester, or I am unable to return at a latter date. 2) I authorize Albertsons Companies and the prior to September 1°, I am either a parent signific on behalf of my child neceiving the vaccine, gregant in my third trimester, or I am unable to return at a latter date. 2) I authorize Albertsons Companies on the contracted third-party payor, including my employer if they are paying directly for my vencionation; the dain in dended. Understand will be responsible for ment; 3) am of legal age and authorized to execute this consent form or I am the parent/guardian of the minor patient, and will be responsible for ment; 3) am of legal age and authorized to execute this consent form or I am the parent/guardian of the minor patient, and will be responsible for ment; 3) and or provided for the parent parent of the parent pare	8. For age under 1	8: Are you taking asp	irin or an aspirin containing medic	ation? (intranasal flu d	nly)						0
Signature of Patient or Parent/Guardian of Minor Patient (put relationship to minor) Below for Pharmacy Use Only: WA ONLY: Substitution Permitted: Vaccine Name Lot # Expiration Date Manufacturer Dose (ml) Manufacturer Dose # Route Site (circle) VIS/EUA Pub. Date COVID-19() Flu () Shingrix** GSK 0.5	y signature below, I conser bertsons Companies or on willity criteria for the vaccina tors, employeas, and agent receiving a flu vaccination is brill a claim for reimburse ent; 3) I am of legal age ar tiveness of the vaccine. 5) if ence any side effects. 6) I e., I should remain in the anne. 7) I have read, or have tions have been answered ibility and Accountability and try, which may share my in try, which may share my in the total of the properting of merstand I have the right to one	nt to the administration of the office affiliated pharmacies to fit affiliated pharmacies to fit and it is from all liability, including and it is prior to September ment on my behalf to Medi did authorized to execute this have been counseled about should remain in the area if each or observation for 30 m had read to me, the Vaccinto my satisfaction. I underset (HIPAA). 3) This vaccination that with othe y receipt of this vaccination	s and to be contacted at the number provide ent/guardian of the minor patient, I attest the sets of omission or commission, resulting, or 1st, I am either a parent signing on behalf of care or any other contracted third-party pays is consent form or I am the parent/guardian of the potential side effects after veccination, who for observation for 15 minutes unless I have a linutes after the vaccination. If I leave the area in Interest after the vaccination of "VIS" or Emerge tand the benefits and risks of the vaccine(s). On, including any vaccination granted additions, and to my primary care provider I understand that to my primary care provider I understand that	d above regarding other imm e minor patient meets eligibil re arising from my receipt or t my child receiving the vaccinor, including my employer if t if the minor patient. 4) I will I en they may occur, and when a history of an immediate alle a without waiting, I acknowle ency Use Authorization ("EUA" 8) I have been offered and/or nal privacy protections under horizing physician, or the loca t failure to check authorize/fix	unizations for which I am due or e ity criteria for the vaccination. I al se minor's receipt of this vaccinate, pregnant in my third trimester, ney are paying directly for my vac- mmediately alert the pharmacist and where I should seek treatme rigic reaction of any severity to a v dage that I am doing so at my own i) provided a copy of the company state or federal law, is subject to I Department of Health, if applica or not authorize will serve as autho	ligible to receive. The sorelease Albertsor ton. I understand: 1 or I am unable to recleation; if the claim of any medical condent. I am responsible accine or injectable risk and against the administered. I have so Notice of Privacy Preporting by my phile, and I authorize rization.) (South Da	ne above Informs Companies, and Information a later I is denied, I utilions which in for following therapy or if I advice of the we had the operactices in companies who is these discloss kota, Maine,	mation is true and its subsic tarily chosen date. 2) I aut inderstand I will nay adversely up with my pi have a histor professional portunity to a mpliance with business asso ures. (New Jer Massachusett	and corre- liaries, affili- to receive to horize Albe- fill be respo- affect my physician at a y of anaphy- who admin sk question the Health- clate to an a sey Only: 1 c s, and New	ct. I atte lates, o the vace ertsons unsible in persona my exp /laxis dr istered is, and insura immuni authoria Hamps	est m fficers complete for al healt ense it ue to a the all my ince ization te shire o
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Counseling (Please circle): Accepted / Declined