Myers Drug 29 S. Chadbourne San Angelo, Texas 76903

Vaccine Screening Questionnaire and Consent Form

****Please provide ALL Insurance Cards ****

Legal Name: ____________________________ **Patient Phone #:** ________________________________

Date of Birth: _________ **Age:** ____ **Gender: M or F**

Address: ____________________________ **City:** ____________________ **State:** _____ **Zip:**_________

Primary Care Physician: _______________________________ (Need address/phone if not in San Angelo)

YES	NO	Please answer the following questions about the person receiving the vaccine:
		Are you sick today?
		Do you have any allergies to medications, food (i.e. eggs), or any vaccine component (e.g. neomycin, gelatin)?
		Have you ever had any serious reactions after receiving a vaccine?
		Are you taking any biological injectables, steroids, anti-cancer drugs or have you had radiation treatments?
		Do you have a neurological disorder such as seizures or other disorder that affects the brain?
		Do you have tuberculosis, cancer, leukemia, AIDS, bone marrow disease or any other immune system problem?
		During the past year, have you received a transfusion of blood or blood products, including antibodies?
		Have you had any vaccinations in the last 4 weeks?
		Are you pregnant or plan to become pregnant within the next month?

I have received 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 consent to, or give consent for, the administration of the vaccine(s). I fully release and discharge Myers Drug, its affiliates, offices, directors and employees from any liability. I authorize the release of any medical or other information with respect to this vaccine to my healthcare providers, the Texas State Department of Health Immtrac Immunization Registry, or third party payer(s) as needed and request payment of authorized benefits to be made on my behalf to Myers Drug.

I understand I may be responsible for payment of copay or in full if not covered by my insurance.

Patient/Parent/Guardian signature____ **Date** ______________

Quadrivalent Inflenza ____ **High Dose** _____ **Prevnar 20** ____ **Pneumovax 23** ____ **Shingrix** ____

FOR PHARMACY USE ONLY			FOR PHARMACY USE ONLY
Vaccine Name:	Count		Vaccine Name:
Manufacturer:	Cash		Manufacturer:
Lot and Expiration:	BT/RX		Lot and Expiration:
Dose: 0.5ML 1ML	Immtrac		Dose: 0.5ML 1ML
Route: IM SQ	EM - MD		Route: IM SQ
SITE: Left Arm Right Arm	FAX PCP		SITE: Left Arm Right Arm

______________________________ ____________ Receipt # ____________________

Signature and Title of Immunizer Date Given

Shared/worddocs/flushotdata/2023 – *WALL ISD*

29 S. Chadbourne
San Angelo, TX 76903
325-655-3146
FAX 325-486-3361

2023 VACCINES

We are unable to provide vaccines to the following:

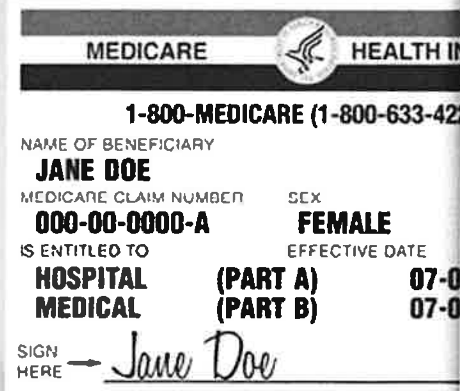
- Hospice patients who have a Medicare advantage plan (such as Aetna or Humana);
- Tricare sponsors and their dependents;
- Some Medicare Advantage Plans (we can check your plan before you get the vaccine);

Tips to help us bill your vaccine correctly:

- Provide us with a copy of ALL your insurance cards.
- Be certain you have the NEW Medicare card – there should be a combination of letters and numbers like this:

New Card! New Number! Mailing in 2018

Current Medicare Card



NEW Medicare Card