Pharmacy~Home Medical Equipment~Gifts
(870) 238-7085 M-F 8:30-6; Sat. 8:30-12
www.caldwellmax.com

Name: ____ Date of Birth: ______________________ Age: __________

Gender (circle one): Male / Female SSN: _____________________________ Race: __________________________

Ethnicity (circle one): Hispanic or Latino/Non-Hispanic or Latino Phone#: ____________________________________

Street Address: ______________________________ City: _____________________ State: _____ Zip Code: __________

Payment: Cash/Medicare/Private Insurance Insurance Cardholder Name & Date of Birth: ________________________________

Screening Questions (if you answer yes, please explain below) **PLEASE CIRCLE**

Question		
1. Are you feeling sick today or have a fever?	Yes	No
2. Do you have allergies to medications, food, a vaccine, component of vaccine, or latex?	Yes	No
3. Have you ever had a serious reaction after receiving a vaccine?	Yes	No
4. Do you have long-term health problems with heart, lung, kidney or metabolic disease (e.g.diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Are you on long-term aspirin therapy?	Yes	No
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	Yes	No
6. Do you have a parent, brother or sister with an immune system problem?	Yes	No
7. In the past 6 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Chron's disease, or psoriasis; or have you had radiation treatments?	Yes	No
8. Have you had Guillain-Barre' Syndrome (GBS), seizures or other brain/nervous system problems?	Yes	No
9. In the past year, have you received blood or blood products, immune (gamma) globulin or an antiviral drug?	Yes	No
10. Have you ever been diagnosed with a heart condition (myocarditis or pericarditis) or have you had Multisystem Inflammatory Syndrome (MIS-A or MIS-C) after an infection with the virus that causes COVID-19?	Yes	No
11. For females: Are you pregnant, breastfeeding or is there a chance you could become pregnant during the next month?	Yes	No
12. Have you received any vaccinations in the past 4 weeks?	Yes	No
13. Have you ever felt dizzy or faint before, during or after a shot?	Yes	No
14. ≥50 years old: Have you had shingles in the last 6 months?		
15. ≥50 years old: Have you ever had a shingles vaccine before?	Yes	No
16. Have you ever had a pneumonia vaccine before? If so, at what age? _________	Yes	No
17. ≥60 years old: Have you ever had a RSV vaccine before?	Yes	No
18. <18 years old: Have you had a well-child visit with your pediatrician in the last 12 months?	Yes	No

Consent and waiver: All of the information I have provided is correct. I consent to the staff to administer the medication(s) mentioned below. I have reviewed the vaccine information sheet (s) and understand the benefits and risks of receiving this medication and choose to assume this risk. I fully release and discharge the standing order physician and the pharmacy, its affiliations and their officers, and employees from any illness, injury, loss, or damage that may result there from. I acknowledge that ***I have received a copy of the pharmacy's privacy policies according to HIPAA***. I assign payment of authorized insurance benefits due to me to be paid to the pharmacy and will pay any copay or deductible that result. I consent the release of medical information when necessary for billing, reimbursement, and medical protocol. I also allow for the pharmacy to report any medications received to the appropriate state vaccine registry and allow the registry to share with other providers. I am aware that an immunization certified student pharmacist or technician might be administering this medication. **I agree to wait near the vaccination area for approximately 20 minutes to receive treatment in case of adverse reaction.**

Vaccine: ____

Signature of patient or guardian: ____