Pharmacy iPack
Free Rx Home Delivery & Walk-in Vaccines

COVID-19 & Flu Vaccination Screening and Consent Form

iPack Pharmacy: 17000 W North Ave STE 108W Brookfield, WI 53005

Instructions: Please complete the following information for the person receiving vaccine, return to pharmacy staff.

***Last Name:**	***First Name:**		Middle Initial:
***Date of Birth:**	***Sex: Male ☐ Female ☐**		
***Address:**	**City:**	**State:**	**ZIP:**
***Cell Phone:**	Home Phone:		

***If you have MEDICARE, but do not have your card (red, white, & blue card) please provide: SSN**: _ _ _-_ _-_ _ _ _

I have read, or have had read to me, the written information regarding the vaccine(s) being administered. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) being administered and have received a copy of a current Vaccine Information Sheet. I, on behalf of myself, my heirs, executors, personal representatives, agents, successors, and assigns hereby agree to release, indemnify, and hold harmless iPack Pharmacy, its subsidiaries, divisions, affiliates, agents, officers, directors, contractors, and employees from any and all claims arising out of, in connection with, or in any way related to the administration of the vaccine(s). I certify that I am at least 18 years old and hereby give my consent to the pharmacists of iPack Pharmacy to administer the vaccine(s). If under 18 years old signature by parent or guardian is required. I agree to wait near the vaccination location for approximately 15 minutes for observation by the pharmacist.

	Health History (Please complete all questions below)	Yes	No	N/A
1	Are you sick today?			
2	Have you ever had an allergic reaction to something? Ie. **Medications, Eggs, latex, Vaccines**			
3	Have you ever had a serious reaction after any vaccination or injectable medication?			
4	Has any physician or other healthcare professional ever cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a medical setting?			
5	In the past 14 days have you had contact with a confirmed COVID-19 patient?			
6	Do you have a long-term health problem such as heart disease, lung disease, liver disease, asthma, or kidney disease?			
7	Have you received passive antibody therapy as a treatment for COVID-19			
8	Are you immunocompromised? *(Taking medication or being treated for cancer, leukemia, HIV/AIDS or other immune system problems or taking medication that affects your immune system)*			
9	Do you have a bleeding disorder(ie. low platelets) or are you taking a blood thinner?			
10	Have you had a seizure or other nervous system problem or Guillain Barre?			
11	Do you have a history of fainting, particularly with vaccines?			
12	**For Women**: Are you breastfeeding or pregnant?			
13	**BOOSTER ONLY:** Which booster would you like? **(CIRCLE ONE) PFIZER MODERNA J&J**			

Signature:	Date: