BI-MART
Your Pharmacy of Choice

COVID-19 Screening Questionnaire (v2020B)

Print Your Name (As it appears on Insurance Card): _____

Date of Birth: _____/_____/_____ **Home Phone: _____**

Email: _____ **Cell Phone: _____**

1. Do you currently have, or have you had, two (2) or more of the symptoms listed below in the last 72 hours that you cannot attribute to another health condition?

- Cough
- Fatigue
- Chills
- Muscle or body aches
- Sore throat
- Nausea or vomiting
- Shortness of breath or Difficulty breathing
- Fever (100.4 degrees or higher)
- Congestion or runny nose
- Headache
- New loss of taste or smell
- Diarrhea

YES NO

2. Within the last 14 days, have you had close contact with someone who is currently sick with suspected or confirmed COVID-19? (Close contact is defined as within 6 ft. for more than 15 minutes).

YES NO

I affirm and certify that my answers above are complete, true and correct to the best of my knowledge and belief.

Patient/Guardian Signature: _____ **Date: ____/____/_____**

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VACCINE ADMINISTRATION RECORD (vU2020A)

Medicare patients residing in a skilled nursing facility are not eligible

Print Your Name (As it appears on Insurance Card): _____

Date of Birth: ____/____/____ **Age:**____ **Gender:** (circle one) **Male** ☐ **Female** ☐

Home Street Address: _____

City, State & Zip: _____ **Home Phone:** _____

Vaccination requested (check up to two): ***Chicken Pox*** ☐ ***Flu*** ☐ *IIV4 HD ADJ Other Vacc. Type*
Hib ☐ ***Hepatitis A*** ☐ ***Hepatitis B*** ☐ ***Hepatitis A+B*** ☐ ***Human Papillomavirus*** ☐
Japanese Encephalitis ☐ ***Measles/Mumps/Rubella*** ☐ ***Meningitis*** ☐ *MenB MenACWY*
Pneumonia ☐ *PCV13 PPSV23* ***Polio*** ☐ ***Rabies*** ☐ ***Shingles*** ☐ *ZVL RZV*
Tetanus/Diphtheria ☐ ***Tet/Dip/Pertussis (Whooping Cough)*** ☐ ***Typhoid – Inactivated (shot)*** ☐
Typhoid – Live (oral) ☐ ***Yellow Fever*** ☐

(Please circle responses and provide details below)

Do you currently feel ill or have a fever? _____ Yes ☐ No ☐
Have you had a severe reaction to a previous vaccination? _____ Yes ☐ No ☐
Do you have any allergies to any food, medicines, vaccines or latex? _____ Yes ☐ No ☐
For women: Are you pregnant or planning to become pregnant soon? _____ Yes ☐ No ☐
Do you or anyone you are in contact with have immune suppression caused by
any drugs and/or diseases such as cancer, AIDS, or leukemia? _____ Yes ☐ No ☐
Are you currently being treated for any chronic diseases such as heart, lung,
or kidney disease, asthma, seizures, diabetes, or blood disorder (anemia)? _____ Yes ☐ No ☐
Have you received any vaccinations in the past 4 weeks? _____ Yes ☐ No ☐
Have you received any transfusions, blood products or been given a medicine
called immune (gamma) globulin within the last year? _____ Yes ☐ No ☐
Are you a Hospice patient covered by Medicare? *(If yes, pharmacy to submit with modifier "GW")* _____ Yes ☐ No ☐

Vaccine administration consent: **I have received the Vaccine Information Statement(s) and have read or have had explained to me the information in that sheet. I have had a chance to ask questions and they were answered to my satisfaction. I recognize and understand that there are benefits and risks associated with any vaccine. I acknowledge that by giving consent, my participation is solely at my own risk, and that I assume full responsibility for any resulting injuries and damages.**

I do, for myself, (and for the recipient of the vaccine if the recipient is a minor), my heirs, executors and assigns, hereby waive, release, and forever discharge Bi-Mart Corporation, its officers, directors, agents and employees, from and against any and all claims, demands, actions or causes of action for damages or personal injury, or death, arising out of or in connection with the quality of the above described vaccine, and any claims for negligence in connection with the related injection of the vaccine.

I understand that some or all of the information on this vaccination record may be required by law to be reported to an immunization registry. I request and authorize the pharmacist to administer the vaccine to me.

Patient/Guardian Signature: _____ **Date:** ___/___/_____

Vaccination #1
Place Pharmacy Prescription Label Here

For injectable vaccines the Sig must contain:

INJECT [*0.5ML* or *1ML*] [*IM* or *SC*] **INTO THE** [*RIGHT* or *LEFT*] [*DELTOID* or *POSTEROLATERAL UPPER ARM*] **BY** [PHARMACIST'S NAME, TITLE], **VACCINE LOT #** XXXXX, **EXP DATE** XX/XX/XX, **VIS VERSION DATE** XX/XX/XX

(FOR PHARMACY USE)

Notes:

Vaccination #2
Place Pharmacy Prescription Label Here

Registry Checked (if required) ☐

Pharmacist Signature - Substitution Permitted

Pharmacist Signature - Dispense as Written