ALVARADO MEDICAL PLAZA PHARMACY

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SCREENING QUESTIONAIRE FOR GARDASIL or HPV VACCINATION

Patient Name: ________________________ Assessment Date: ____/____/20____

Weight _____(lbs) _____(kgs) Date of Birth: ____/____/_____

PATIENTS: The following questions will help us determine if the Gardasil or HPV vaccine is appropriate to administer to you today. If a question is not clear, please ask the Pharmacist to further explain

	YES	NO	Don't Know
1. Are you a girl or young woman between the ages of 13-26? (HPV vaccine is only FDA for this age group)	☐	☐	☐
2. If you are **under** the age of 18, we **require** written consent from your parent or legal guardan on this form.	☐	☐	☐
3. Are you ill (sick) tody? *(Do you have a temperature of 101.3F degrees or higher?)*	☐	☐	☐
4. Have you had an allergic reaction to **any previous vaccinations**?	☐	☐	☐
5. Are you allergic to **yeast**?	☐	☐	☐
6. Are you currently being treated for any immune disorders (HIV/AIDS, cancers, bone marrow, lymphatic diseases or taking any medications such as Prednisone or any other corticosteroids? *(Taking medications or having a disease that can reduce the body's immune response can result in a decrease in the effectiveness of the vaccine.)*	☐	☐	☐
7. Are you aware that HPV Vaccine is administered in 3 doses or a "three-series" shot? *(First shot now, second in 2 months and the final shot at 6 months.)*	☐	☐	☐
8. Are you pregnant or is there a chance you could become pregnant? (**Pregnant women should not get the vaccine.**)	☐	☐	☐

I have read, or have had explained to me, the question listed above. I have had the opportunity to ask questions that were answered to my satisfaction. I have read and been provided the current Gardasil or HPV VIS (Vaccination Information Statement) published by the CDC. I understand the benefits and risks of the vaccination cited and request this vaccination to be administered intramuscularly to myself or the person listed above (for whom I am authorized to make this request). For first time vaccinations, I understand that it is essential that I remain on location for approximately 15 (fifteen) minutes following administration.

Form consent/completed by: ______________________________ Date: ____/____/20___

---OFFICE USE ONLY---

Vaccination Administered by: _____________________________

Did the patient experience any reaction? ☐ YES ☐ NO