(Pharmacy/Off Site Clinic Information)

Vaccine Consent & Assessment

Date Faxed to PCP/Protocol Physician: ___/___/___
Added to KSWebIZ electronically through ComputerRX

Vaccine(s) Requested (circle all that apply): **Flu** **Pneumonia** **Tetanus, Diphtheria +/- Pertussis (Whooping Cough)**
Measles/Mumps/Rubella (MMR)* **Hepatitis A** **Hepatitis B** **Meningitis** **Shingrix / Zostavax*** **Other** _____

FIRST NAME	MI	LAST NAME	DATE OF BIRTH	AGE	GENDER
			/ /		M F

ADDRESS	CITY	STATE	ZIP	PHONE

PRIMARY CARE PHYSICIAN	INSURANCE NAME/ID #	INSURANCE PHONE #

	The following questions will help us assess safety and appropriateness of being vaccinated today	YES	NO
ALL VACCINES	1. Do you have a fever or illness today? (Avoid all vaccines with fever >101°F although mild illness is NOT contraindicated to vaccinate)		
	2. Are you 50 years of age or older? (Shingrix)		
	2. Are you 65 years of age or older?(Fluzone HD, Prevnar, Pneumovax - 1 year after Prevnar)		
	3. Do you have a long-term health problem with heart disease (e.g., heart attack), lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder? (Pneumovax recommended age 19-64 years)		
	4. Do you smoke, have asthma, COPD or emphysema? (Pneumovax recommended age 19-64 years)		
	5. Do you have allergies to any medications, food (e.g. eggs), vaccine components (e.g. diphtheria toxoid, gelatin, neomycin, polymyxin, yeast, thimerosal, aluminum etc.), or latex? *If yes, please list:* _____		
	6. Have you ever had a serious reaction after receiving a vaccination i.e., swelling, trouble breathing, seizure, etc.?		
	7. Have you experienced seizures, Guillain-Barre Syndrome, or any other neurological problem? (Flu, Td/Tdap, Menactra)		
	8. For Women: Are you currently pregnant, breastfeeding, or planning to become pregnant in the next 3 months? (Written or verbal prescription required from OB/GYN or PCP to administer vaccination)		
LIVE VACCINES*	9. Have you received any vaccines in the past 28 days *or* plan to receive any in the next 28 days?		
	10. Have you been diagnosed with a condition that significantly weakens your immune system (cancer, leukemia, lymphoma, HIV/AIDS, organ transplantation, or any other immune system problem)?		
	11. In the past 3 months, have you taken medications that affect your immune system such as high-dose steroids or chemotherapy, treatment of rheumatoid arthritis, Crohn's disease, or psoriasis (e.g., Humira, Enbrel); or have you had radiation treatments? *If yes, list medication, dose, and date last taken:* _____		
	12. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or any antiviral**drug? *If yes, list medication, dose, and date last taken:* _____		
	13. Do you have active Tuberculosis or have you experienced a shingles rash in the past 5 months?		
	14. Do you live with an immunosuppressed individual or a person with any of the above stated health conditions?		

I hereby give my consent to the healthcare provider of this pharmacy, to administer the vaccine(s) indicated above to me or the person named below for whom I am authorized to make this request. I understand the risks and benefits associated with the vaccine(s) being administered and have received, read and/or had explained to me the written information regarding the vaccine(s) I requested and have received a copy of the Vaccine Information Statement (VIS). I have had the opportunity to ask questions that were answered to my satisfaction. I, on behalf of myself, my heirs, executors, personal representatives, agents, successors, and assigns hereby agree to release, indemnify, and hold harmless the pharmacy, Dr. Donna Sweet, MD, its subsidiaries, divisions, affiliates, agents, officers, directors, contractors, and employees from any and all liabilities or claims arising out of, in connection with, or in any way related to the administration of the vaccine(s) requested or any medications related to the administration of the vaccine(s). I understand that a copy of the information on this form will be sent to my primary physician (if listed and known) or the pharmacy's protocol doctor. I understand that the information contained on this form may be shared with the State Health Department and Kansas Immunization Registry, and will remain confidential and will not be released except as permitted or required by law. If eligible, I authorize this pharmacy to submit a claim for reimbursement on my behalf to Medicare or any other contracted third party payer. If the claim is denied, I understand that I will be responsible for payment. I am authorizing any holder of medical or other information about myself to be released to Centers for Medicare and Medicaid Services (CMS) and its agents, including any information needed to determine any and all benefits for related services. The pharmacy protects the confidentiality of your health information. I have received the Notice of Privacy Practices. Furthermore, I agree to remain near the vaccination location for approximately 15-20 minutes after administration of the vaccine(s) for observation.

X _____

SIGNATURE OF PERSON TO RECEIVE THE VACCINE OR PERSON AUTHORIZED TO MAKE THE REQUEST (PARENT OR GUARDIAN) DATE

---------- For Pharmacy Use Only ----------

IMMUNIZER/SIGNATURE:			TITLE:	SUPERVISING RPH:		DATE OF IMMUNIZATION/VIS GIVEN:		
Vaccine Name:	**Lot#:**	**Exp Date:**	**Diluent Lot#/Exp:**	**MFG:**	**Dosage:**	**Site:**	**Route:**	**VIS Date:**
						LA RA	IM SQ	
						LA RA	IM SQ	
						LA RA	IM SQ	