THE KROGER CO. FAMILY OF PHARMACIES

VACCINE CONSENT & ASSESSMENT

(Pharmacy/Off Site Clinic Information)

☐Faxed Date: __/__/__ ☐Registry Date: __/__/___

First Name:	MI:	Last Name:			
Home Phone: ( ) -	Date of Birth: / /	Age:	Weight:	Gender:	Ethnicity:
Home Address:	City:			State:	Zip Code:
Primary Care Provider:	Provider Address:			Provider Phone: ( ) -	
Insurance Carrier:	Cardholder ID:			Group Number:	

I WANT TO BE PROTECTED FROM THE FOLLOWING (*PLEASE CHECK ALL THAT APPLY*):

☐ FLU ☐ HEPATITIS A ☐ HEPATITIS B ☐ HPV ☐ *MEASLES/MUMPS/RUBELLA (MMR)** ☐ MENINGITIS ☐ PNEUMONIA

☐ *SHINGLES** ☐ TETANUS, DIPHTHERIA, +/- PERTUSSIS ☐ *VARICELLA** ☐ OTHER (*PLEASE SPECIFY*):_____

	Please answer the following questions so we can assess the safety and the appropriateness of vaccination:	Yes	No
ALL VACCINES	1. Do you have a fever or illness today?		
	2. Do you have any allergies to medications, foods (e.g. eggs), latex, or a vaccine component (e.g. gelatin, neomycin, polymyxin, yeast, thimerosal, etc.)? If yes, please list what you are allergic to:_____		
	3. Have you ever had a serious reaction after receiving a vaccine? (swelling, trouble breathing, seizure, etc.)		
	4. Have you ever received the SAME vaccine that you are requesting today (not including previous year's flu vaccine)?		
	5. Have you experienced seizures, Guillain-Barre Syndrome, or any other neurological disorder?		
	6. Have you received any vaccines in the past 28 days? If yes, please list vaccine and date:_____		
	7. **For Women**: Are you currently pregnant, breastfeeding, or are you planning to become pregnant in the next month?		
*LIVE VACCINES	8. Do you have cancer, leukemia, lymphoma, HIV/AIDS, organ transplantation, or any other immune system problem?		
	9. In the past 3 months, have you taken medications that weaken your immune system, such as anticancer drugs, high-dose steroids, chemotherapy, injectable therapy for rheumatoid arthritis, Crohn's disease or psoriasis (e.g. Humira, Enbrel) or had radiation treatments? If yes, list medication, dose, and date last taken:_____		
	10. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? If yes, list medication, dose, and date last taken:_____		

I hereby give my consent to the healthcare provider of The Kroger Co., to administer the vaccine(s) I have requested above. I understand the risks and benefits associated with the vaccine(s) being administered and have received, read and/or had explained to me the CDC's Vaccine Information Statement (VIS) on the vaccine(s) I have elected to receive. I have had the opportunity to ask questions that were answered to my satisfaction. As with all medical treatment, there is no guarantee that I will not experience an adverse reaction from the vaccine. I fully release and hold harmless The Kroger Co., 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) listed above. I understand that the information contained on this form may be shared with the Stated Health Division (SHD) and/or state immunization registries, and will remain confidential and will not be released except as permitted or required by law. If eligible, I authorize Kroger to submit a claim for reimbursement on my behalf to Medicare or any other contracted third party payor. If the claim is denied, I understand that I will be responsible for payment. I acknowledge that I have received a copy of the Kroger Pharmacy Notice of Privacy Practices. **Furthermore, I agree to remain near the vaccination location for approximately 15-20 minutes after administration for observation by the administering healthcare provider.**

X_____ **Date:** _____

(SIGNATURE OF PATIENT OR LEGAL GUARDIAN, IF PATIENT UNDER AGE 18) (FOR LEGAL GUARDIANS ONLY: PRINT NAME and RELATIONSHIP)

(For Pharmacy Use Only) *The following section is to be completed by the pharmacy:*

Vaccine Name: _____	Vaccine Name: _____	Vaccine Name: _____
Manufacturer: _____	Manufacturer: _____	Manufacturer: _____
Dose: _____	Dose: _____	Dose: _____
Vaccine Lot #: _____	Vaccine Lot #: _____	Vaccine Lot #: _____
Vaccine Exp. Date: _____	Vaccine Exp. Date: _____	Vaccine Exp. Date: _____
Diluent Lot #/Exp. Date: _____	Diluent Lot #/Exp. Date: _____	Diluent Lot #/Exp. Date: _____
Injection Site: LEFT ARM RIGHT ARM	**Injection Site: LEFT ARM RIGHT ARM**	**Injection Site: LEFT ARM RIGHT ARM**
Route: IM SubQ	**Route: IM SubQ**	**Route: IM SubQ**
Immunizer: _____RPh/Intern	Immunizer: _____RPh/Intern	Immunizer: _____RPh/Intern
Supervising RPh/Lic#:_____	Supervising RPh/Lic#:_____	Supervising RPh/Lic#:_____
Date Administered/VIS Given:____/____/____	Date Administered/VIS Given:____/____/____	Date Administered/VIS Given:____/____/____
VIS Version Date: ____/____/____	VIS Version Date: ____/____/____	VIS Version Date: ____/____/____