Last Updated August 2023

Vaccine Consent & Assessment

Dated Faxed to PCP/Protocol Physician:

Vaccine(s) Requested *(check all that apply):*

☐ **Flu** ☐ **Pneumonia** ☐ **Tetanus, Diphtheria +/- Pertussis (Whooping Cough)**

☐ **Hepatitis A / B** ☐ **RSV** ☐ **Shingrix** (○ 1st or ○ 2nd) ☐ **COVID (Strain:)** ☐ **Other**

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

ADDRESS	CITY	STATE	ZIP	PHONE

PRIMARY CARE PHYSICIAN	MEDICARE A/B # or INSURANCE NAME/ID #	RACE/ETHNICITY YOU IDENTIFY WITH

	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)	○	○
ALL VACCINES	**2. 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:*	○	○
ALL VACCINES	**3. Have you ever had a serious allergic reaction after receiving a vaccination i.e., swelling, trouble breathing, fainting, seizure, etc.?** *If yes, please list:*	○	○
ALL VACCINES	**4. Have you experienced seizures, Guillain-Barre Syndrome, or any other neurological problem?** (Flu, Td/Tdap)	○	○
ALL VACCINES	**5. Are you considered moderately/severely immunocompromised per CDC guidelines (e.g. rc'd organ transplant, rc'd immunosuppressants, advanced/untreated HIV, rc'ing active cancer treatment for tumors/cancers of the blood, etc.)** (Prevnar20 or refer to Pneumococcal reference guide if previous pneumonia vaccine)	○	○
ALL VACCINES	**6. 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:*	○	○
ALL VACCINES	**7. For COVID-19 Vaccine ONLY: When was your last dose?**	/ /	
ARE YOU UP TO DATE?	**1. Are you 50 years of age or older?** - 50 years + = Shingrix - 60 years + = RSV - 65 years + = HD Flu, Tdap, Prevnar20 or refer to Pneumococcal reference guide if previous pneumonia vaccine	○	○
ARE YOU UP TO DATE?	**2. Do you have diabetes? (Hepatitis B, Refer to Pneumococcal reference guide)**	○	○
ARE YOU UP TO DATE?	**3. Do you smoke, have asthma, COPD, emphysema, heart disease, lung disease, kidney disease, anemia, or other blood disorder? (Prevnar20 or refer to Pneumococcal reference guide if previous pneumonia vaccine)**	○	○
ARE YOU UP TO DATE?	**4. Are you / will be in contact with a newborn? (Tdap)**	○	○
ARE YOU UP TO DATE?	**5. For Women: Are you pregnant, breastfeeding, or planning to become pregnant in the next 3 months? (Tdap or 32 to 36 weeks pregnant = RSV)**	○	○

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. Ronald Ferris, 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 _____ **Date:** _____

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

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

Vaccine Name:	Lot#:	Exp Date:	Diluent Lot#/Exp:	MFG:	Dosage:	Deltoid Site:	VIS Date:
						○ LA ○ RA	
						○ LA ○ RA	
						○ LA ○ RA	
						○ LA ○ RA	