VACCINE CONSENT FORM

☐ Immunizer Name:	(Internal/Off Site Clinic Info)
☐ Phone/Fax Date:_____/_____/_____	
☐ Phone/Fax Time: ____:____ AM/PM	
☐ Registry Date: _____/_____/_____	

First Name:	MI:	Last Name:	Date of Birth: / /	Sex Assigned at Birth:	Age:	Weight:
Home Phone:	Race: ☐ Black or African American ☐ American Indian or Alaska Native ☐ Hispanic/Latino ☐ White ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Other ☐ Not specified				Ethnicity: ☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Not specified	
Home Address:		City:		State:	Zip Code:	
Primary Healthcare Provider:	Provider Address:			Provider Phone:	Provider Fax:	
Are you covered by commercial or federally funded healthcare insurance? ☐ YES ☐ NO				If **NO**, provide State Issued ID (preferred) or Social Security Number:		
If **YES**, provide Insurance Carrier:	If **YES**, provide Cardholder ID Number:			If **YES**, provide Group Number:		

I WANT TO BE PROTECTED FROM THE FOLLOWING (*CHECK ALL THAT APPLY*): ☐ FLU ☐ HEPATITIS A ☐ HEPATITIS B ☐ HPV ☐ TDAP ☐ SHINGLES ☐ *MEASLES/MUMPS/RUBELLA (MMR)** ☐ MENINGITIS ☐ PNEUMONIA ☐ *VARICELLA** ☐ COVID-19: PRODUCT _____ ☐ OTHER: _____

	Please answer the following questions to help us make sure the vaccine is right for you:	Yes	No
ALL VACCINES	1. Do you have any of the following symptoms today? Fever, cough, shortness of breath, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, diarrhea		
	2. In the past 14 days, have you had a fever or been exposed to or diagnosed with COVID-19, regardless of symptoms?		
	3. Have you had a physical examination by a healthcare provider in the last year?		
	4. Do you have any allergies to medications, foods (e.g. eggs), latex, or a vaccine component (e.g. gelatin, neomycin, polymyxin, yeast, thimerosal, polyethylene glycol, etc.)? If yes, please list what you are allergic to:_____		
	5. Have you ever had a serious reaction after receiving a vaccine? (swelling, trouble breathing, seizure, etc.)		
	6. Have you had the vaccine (s) you are receiving today before?		
	7. Have you experienced seizures, Guillain-Barre Syndrome, or any other neurological disorder?		
	8. Have you received any vaccines in the past 28 days? If yes, please list vaccine and date:_____		
	9. **For Women**: Are you currently pregnant, breastfeeding, or are you planning to become pregnant in the next month?		
	10. During the past year, have you received a transfusion of blood or blood products, been given immune (gamma) globulin or an antiviral drug, or received COVID-19 antibody treatment? If yes, list medication, dose, and date last taken:_____		
*LIVE	11. Do you have cancer, leukemia, lymphoma, HIV/AIDS, organ transplantation, or any other immune system problem?		
	12. 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:_____		

I hereby give my consent to the health care provider of The Kroger Co., its affiliates and subsidiaries, 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 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 Notice of Privacy Practices.
Furthermore, I agree to remain near the vaccination location for approximately 15-30 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 INTERNAL USE ONLY *** ☐ **REQUIRED**: obtained verbal consent to treat prior to administration ☐ If <18, recommend Well-Child Visit

Vaccine Name:_____	Vaccine Name:_____	Vaccine Name:_____
Manufacturer:_____	Manufacturer:_____	Manufacturer:_____
Dose:_____ Series #:_____ of ____	Dose:_____ Series #:____ of ____	Dose:_____ Series #:_____ of _____
Vaccine Lot #:_____ Exp. Date:_____	Vaccine Lot #:_____ Exp. Date:_____	Vaccine Lot #:_____ Exp. Date:_____
Diluent Lot #/Exp. Date:_____	Diluent Lot #/Exp. Date:_____	Diluent Lot #/Exp. Date:_____
Injection Site: **LEFT/RIGHT; ARM/THIGH**	Injection Site: **LEFT/RIGHT; ARM/THIGH**	Injection Site: **LEFT/RIGHT; ARM/THIGH**
Route: **IM** or **SubQ**	Route: **IM** or **SubQ**	Route: **IM** or **SubQ**
VIS or EUA Fact Sheet Given: ____/____/____	VIS or EUA Fact Sheet Given: ____/____/___	VIS of EUA Fact Sheet Given: ___/___/___
Version Date: ____/____/____	Version Date: ____/____/____	Version Date: ____/____/____

☐ **REQUIRED**: counseled patient to remain near location for 15 to 30 mins Supervising RPh/Lic#:_____ *(if required)*
Immunizer:_____ Date Administered:___/___/___ Time: _____AM/PM