The Little Clinic

THE KROGER CO. FAMILY OF PHARMACIES

(Internal/Off Site Clinic Information)

☐Phone/Fax Date:__/__/__ ☐RPh/Tech Name:_____

☐Phone/Fax Time:____AM/PM ☐Registry Date: __/__/____

VACCINE CONSENT FORM

First Name:	MI:	Last Name:			
Home Phone: ( ) -	Date of Birth: / /	Age:	Weight:	Gender:	Ethnicity:
Home Address:	City:			State:	Zip Code:
Primary Healthcare 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 ☐ TDAP ☐ *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. Have you had a physical examination by a healthcare provider in the last year?		
	2. Do you have a fever or illness today?		
	3. 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:_____		
	4. Have you ever had a serious reaction after receiving a vaccine? (swelling, trouble breathing, seizure, etc.)		
	5. Have you had the vaccine (s) you are receiving today before?		
	6. Have you experienced seizures, Guillain-Barre Syndrome, or any other neurological disorder?		
	7. Have you received any vaccines in the past 28 days? If yes, please list vaccine and date:_____		
	8. **For Women**: Are you currently pregnant, breastfeeding, or are you planning to become pregnant in the next month?		
*LIVE VACCINES	9. Do you have cancer, leukemia, lymphoma, HIV/AIDS, organ transplantation, or any other immune system problem?		
	10. 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:_____		
	11. 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 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 15-20 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 INTERNAL USE ONLY ***

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

Supervising RPh/Lic#:_____ (if required)

Immunizer:_____ RPh/Intern/NP/PA/LPN/RN Date Administered:___/___/___ Time: _____AM/PM