



# COVID-19 & FLU (Influenza) Vaccine Screening and Consent Form - 2025-26

KTA Pharmacy  
50 E. Puainako St  
Hilo, HI 96720  
808-959-8700

## Section 1: Patient Information

First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_ Last Name: \_\_\_\_\_ Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_  
Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Gender: ☐ Male ☐ Female ☐ Other  
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

## Section 2: Information Required By Hawai'i State Immunization Registry System

Race: ☐ Asian ☐ White ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American  
☐ American Indian or Alaska Native ☐ Other ☐ Not Specified

Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Unknown Mother's Maiden Name: \_\_\_\_\_

## Section 3: Insurance Information

Do you have Medicare? ☐ No ☐ Yes → Medicare Number: \_\_\_\_\_ → Last 4 of SSN: \_\_\_\_\_

Do you have Medicaid? ☐ No ☐ Yes → Medicaid Number: \_\_\_\_\_

Do you have insurance? ☐ No ☐ Yes → Insurance: \_\_\_\_\_ Policy/ID#: \_\_\_\_\_

Are you the policyholder? ☐ Yes ☐ No → I am: ☐ Spouse ☐ Child → Policyholder Name: \_\_\_\_\_

Primary care provider name: \_\_\_\_\_

Which vaccine(s) would you like to receive today: ☐ Flu (Influenza) Vaccine ☐ COVID-19 Vaccine

## Section 4: Screening Questionnaire

|   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| Are you sick today?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have an allergy to any medications, food, vaccine, or latex? List: | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a serious reaction after receiving a vaccine?           | <input type="checkbox"/> | <input type="checkbox"/> |

### Section 4a: Complete this section if receiving FLU vaccine

|   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| Have you ever had Guillian-Barre Syndrome?                              | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a seizure or a brain or other nervous system problem? | <input type="checkbox"/> | <input type="checkbox"/> |

### Section 4b: Complete this section if receiving COVID-19 vaccine

|   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| Have you ever been diagnosed with myocarditis or pericarditis?          | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had Multisystem Inflammatory Syndrome (MIS-A or MIS-C)?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Has it been a minimum of 60 days since your last COVID-19 vaccine dose? | <input type="checkbox"/> | <input type="checkbox"/> |

By initialing here: \_\_\_\_\_ I attest that I am at least 65 years of age OR have at least one underlying condition that puts me at high risk for severe outcomes from COVID-19 (see reverse for complete list of conditions).

## Section 5: Vaccine Administration Consent

**Consent for Service:** I request the vaccine to be given to me or to the person named above, whom I represent, and I am authorized to sign this consent form. I understand the benefits and risks of the COVID-19 and/or influenza vaccine as described in the Vaccine Information Statement (or EUA) Sheet which was provided with this consent. I have had a chance to ask questions that were answered to my satisfaction. I agree to stay in the vaccine administration area for fifteen (15) minutes or longer if indicated by the vaccine administrator after receiving my vaccine to ensure that no immediate adverse reactions occur. I understand that currently, some COVID-19 vaccines require multiple doses dependent on the manufacturer. If this is my first dose of the COVID-19 vaccine and a second or third dose is required, I intend to receive subsequent doses of the same vaccine in accordance with the timeframe specified in the Fact Sheet to complete the series. **Limitation of Liability:** I understand that KTA Super Stores, its divisions and affiliates and their respective officers, directors, employees, agents and representatives are immune from civil liability under federal and state law for all claims for loss related to any known or unknown side effects and/or injuries, including but not limited to death, that I, or the person for whom I am authorized to make this request, may experience from this vaccine. This immunity means that if I file a lawsuit against KTA Super Stores, the court must dismiss any such lawsuit, and the only exception to this immunity is for claims for willful misconduct. **Authorization to Release Information for Medical Treatment and/or Payment:** I understand that I am giving KTA Super Stores permission to release any medical or other information necessary to my physician, Medicare, Medicare HMO, or insurance company, as applicable, to enable the pharmacy to process my insurance claims with respect to the vaccination.

X  
Signature of Person to Receive Vaccine / Parent or Legal Guardian

Printed Name of Parent or Legal Guardian

Date

### BELOW LINE FOR PHARMACY USE ONLY

Date of Admin/VIS given: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Time of Administration: \_\_\_\_\_:

Administering Pharmacist, PharmD.

Clinic location:

☐ Flu (Influenza)

VIS Date: 1/31/25 Dosage: 0.5ml

Site/Route: ☐ Left Deltoid, IM

☐ Right Deltoid, IM

☐ COVID-19, 2025-26

VIS Date: 1/31/25 Dosage: 0.5ml

Site/Route: ☐ Left Deltoid, IM

☐ Right Deltoid, IM



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The 2025-26 COVID-19 vaccine is approved for use in individuals who are:

- 65 years of age and older, or
- 3 years through 64 years of age with at least one underlying condition that puts them at high risk for severe outcomes for COVID-19.

If you have one or more of the conditions listed below, you are more likely to get very sick from COVID-19 and be hospitalized, need intensive care, require a ventilator to breathe, and/or die. The conditions on this list are in alphabetical order. They are not in order of risk.

This list does not include all medical conditions that place a person at higher risk of severe illness from COVID-19. Rare medical conditions, including many conditions that mostly affect children, may not be included. A person with a condition that is not listed may still be at greater risk of getting very sick from COVID-19 than other people. It is important to talk with your healthcare provider about your risk.

## Please check all that apply to you:

- ☐ Cancer
- ☐ Cerebrovascular disease
- ☐ Chronic kidney disease (at any stage)
- ☐ Chronic liver disease
- ☐ Chronic lung disease
- ☐ Cystic fibrosis
- ☐ Dementia or other neurological conditions
- ☐ Diabetes (Type 1 or Type 2)
- ☐ Disabilities
- ☐ Heart Conditions
- ☐ Hemoglobin blood disorders
- ☐ HIV infection (human immunodeficiency virus)
- ☐ Immunocompromised condition or weakened immune system
- ☐ Mental health conditions
- ☐ Overweight and obesity
- ☐ Physical inactivity
- ☐ Pregnancy
- ☐ Smoking - current or former
- ☐ Solid organ or blood stem cell transplant
- ☐ Substance use disorders
- ☐ Tuberculosis (TB)