Vaccination Consent and Release

Last Name of Patient | First Name | Middle | Birthdate | Gender | Mother's Maiden Name (Optional)

Address | City | State | Zipcode | Phone Number

Primary Insurance Name | Insurance ID | Name of Primary Care Physician to be notified via Fax

I acknowledge that I understand the benefits and risks of the requested vaccination as described in the Vaccine Information Sheet. I confirm that KTA Super Stores, on behalf of its pharmacy operations in all divisions, has answered to my satisfaction all of my questions about the vaccine and the vaccination procedure. I request and consent that the vaccination be given, as I direct KTA, to me. I understand that I am giving KTA permission to release any medical or other information necessary to my physician, Medicare, Medicare HMO, or insurance company, as applicable, to enable KTA to process my insurance claims with respect to the vaccination. I, for myself, my heirs, executors and assigns hereby release KTA and its divisions and affiliates and their respective officers, directors, employees, agents and representatives from any and all claims arising out of or in connection with the quality of the above described vaccine as provided by the manufacturer and any negligence of KTA in connection with the related injection of the vaccination. I understand that the laws of my state may affect my remedies in connection with this vaccination.

Signature of Person to Receive Vaccine | Date

		Please answer these questions by checking the boxes. If the question is not clear, please ask the pharmacist.	Yes	No	Don't Know
All Vaccines	1.	Are you sick today?			
	2.	Do you have a serious allergy to medications or food or any vaccines? *Example: Eggs, Gelatin, Thimerosal, Neomycin,*			
	3.	Have you ever had a serious reaction after receiving any vaccination?			
Influenza, Td, Tdap	4.	Do you have a seizure disorder, brain disorder, or history of Guillain-Barre syndrome?			
HepB	5.	Are you currently receiving dialysis treatment? For Hep B, Please also answer Question 8.			
MMR-II Varicella	6.	Do you have cancer, leukemia, HIV, or any other immune system problem?			
	7.	In the past 3 months, have you taken medication that affect your immune system such as cortisone, prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatment?			
	8.	During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin?			
	9.	Have you received any vaccinations in the past 4 weeks?			
	10.	For women: Are you pregnant or are you considering becoming pregnant?			
Vaccination Screening	11.	If you are over the age of 65, have you ever had a pneumococcal vaccination?			
	12.	If you are over the age of 50, have you ever had a shingles vaccination?			
	13.	If you are under the age of 26, have you ever received the human papilloma virus vaccination?			
	14.	Have you ever been vaccinated for the whooping cough vaccination? If yes, Date: _____			

---------- BELOW FOR PHARMACY USE ONLY (Rx) ----------

Select	Vaccine	Brand Name	Mftr	Lot #	Exp. Date	VIS Date	Dosage	Site of Injection	Time
	Hepatitis A					7/20/2016		IM L / R Deltoid	
	Hepatitis B	Engerix B®	Merck			8/15/2019	1ml	IM L / R Deltoid	
	9vHPV	Gardasil®9	Merck			10/30/2019	0.5ml	IM L / R Deltoid	
	Influenza					8/15/2019	0.5ml	IM L / R Deltoid	
	PCV13	Prevnar 13®	Pfizer			10/30/2019	0.5ml	IM L / R Deltoid	
	PPSV23	Pneumovax® 23	Merck			10/30/2019	0.5ml	IM L / R Deltoid	
	MMR	M-M-R II	Merck			8/15/2019	0.5ml	SQ L / R Arm	
	Tdap	Boostrix®	GSK			4/01/2020	0.5ml	IM L / R Deltoid	
	Zoster	Shingrix®	GSK			10/30/2019	0.5ml	IM L / R Deltoid	

Signature of Pharmacist: _____ Date VIS/IMZ provided to patient: _____

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From: KTA Super Stores

◯ **Puainako Pharmacy Ph: (808) 959-8700 Fax: (808) 959-7559**
◯ **Keauhou Pharmacy Ph: (808) 322-2511 Fax: (808) 322-1832**
◯ **Waimea Pharmacy Ph: (808) 885-0033 Fax: (808) 885-0397**
◯ **Waikoloa Village Pharmacy Ph: (808) 883-8434 Fax: (808) 883-8540**

Faxed _____ Eligibility _____ Billed _____ Checked _____ HIR/CoCASA _____