Vaccination Consent & Release Form

(updated 8/19/25)

Clinic Location:

Last Name of Recipient	First Name	Middle Name	Birthdate	Age	Gender

Address	City	State	Zip Code	Phone Number

Primary MEDICAL Insurer (HMSA, UHA, Kaiser, etc.):	Primary MEDICAL Insurance ID:	Medicare Part B No or SSN:

Secondary MEDICAL Insurer:	Secondary MEDICAL Insurance ID:	☐ I have no Health Insurance

Primary Care Provider's (MD, ARNP, PA, NP, etc.) Name:	Primary Care Provider Phone #:	Mother's Maiden Name:

Recipient Ethnicity (Check ONE): ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown / Not Reported

Recipient's Race (Check ONE): ☐ Native American or Alaska Native ☐ Pacific Islander or Native Hawaiian ☐ Asian ☐ White ☐ Black or African American ☐ Other

----------**BELOW LINE FOR PHARMACY USE ONLY**----------

	Vaccine	Brand Name	Mfr	VIS Date	Dosage	Lot #	Exp. Date	Site of Injection (Circle one)		Time
	COVID-19			1/31/25				IM	L / R Deltoid	
	Hepatitis A	Vaqta ®	Merck	1/31/25	50U			IM	L / R Deltoid	
	Hepatitis B	Engerix B ®	Merck	1/31/25	20mcg			IM	L / R Deltoid	
	HPV	Gardasil®	Merck	8/6/21	0.5ml			IM	L / R Deltoid	
	Influenza			1/31/25	0.5ml			IM	L / R Deltoid	
	Influenza HD			1/31/25	0.5ml			IM	L / R Deltoid	
	PCV-20	Prevnar20 ®	Pfizer	5/29/25	0.5ml			IM	L / R Deltoid	
	MenACWY	Menquadfi ®	Sanofi	1/31/25	0.5ml			IM	L / R Deltoid	
	MMR	M-M-R II®	Merck	8/6/21	0.5ml			SQ	L / R Arm	
	Td	Tenivac®	Sanofi	8/6/21	0.5ml			IM	L / R Deltoid	
	Tdap	Boostrix®	GSK	1/31/25	0.5ml			IM	L / R Deltoid	
	Zoster	Shingrix®	GSK	2/4/22	0.5ml			IM	L / R Deltoid	
	Varicella	Varivax®	Merck	1/31/25	0.5ml			SQ	L / R Arm	
	RSV	Abrysvo ®	Pfizer	1/31/25	0.5ml			IM	L / R Arm	

Signature of Administering Pharmacist:_____ Date VIS given and Administration:_____

Please answer these questions by checking the boxes. If the question is not clear, please ask the pharmacist.

All Vaccines	Yes	No	Don't Know
1. Is the person to be vaccinated sick today?			
2. Does the person to be vaccinated have a serious allergy to medications, food, or any vaccines? Example: Eggs, Gelatin, Thimerosal, Neomycin, Gentamicin			
3. Has the person to be vaccinated ever had a serious reaction after receiving any vaccination or other injectable medication? *(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)*			
4. For women: Are you pregnant or are you considering becoming pregnant? If YES, please indicate how far along you are:_____ weeks			
5. Have you ever felt dizzy or faint before, or after a shot?			
Influenza, Td, Tdap			
6. Does the person to be vaccinated have a seizure disorder, brain disorder, or history of Guillain-Barre syndrome?			
Hepatitis B			
7. Is the person to be vaccinated receiving dialysis 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 or an antiviral drug?			
MMR-II, Varicella			
9. Do you have cancer, leukemia, HIV, or any other Immune system problem			
10. 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?			
11. During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin or an antiviral drug?			
12. Have you received any vaccinations in the past 4 weeks?			
COVID-19			
13. Has the person to be vaccinated ever received a dose of COVID-19 vaccine? Was the most recent dose of COVID19 vaccine more than 2 months ago? ____YES _____NO			
14. Have you ever been diagnosed with a heart condition (myocarditis or pericarditis) or have you had Multisystem Inflammatory Syndrome (MIS-A or MIS-C) after an infection with the virus that causes COVID-19?			

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