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: _____

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

	Vaccine	Brand Name	Mfr	VIS Date	Dosage	Lot #	Exp. Date	Site of Injection (Circle one)		Time
	COVID-19	Spikevax®	Moderna	1/31/25	0.5ml			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	Flucelvax ®	Seqirus	1/31/25	0.5ml			IM	L / R Deltoid	
	Influenza HD	Fluad ®	Seqirus	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 Deltoid	

Signature of Administering Pharmacist:_____

Date VIS given and Administration:_____

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Section 4: Screening Questionnaire	YES	NO
Are you sick today?	☐	☐
Do you have an allergy to any medications, food, vaccine, or latex? List:	☐	☐
Have you ever had a serious reaction after receiving a vaccine?	☐	☐
Section 4a: Complete this section if receiving FLU, Td, or Tdap vaccine	YES	NO
Have you ever had Guillian-Barre Syndrome?	☐	☐
Have you ever had a seizure or a brain or other nervous system problem?	☐	☐
Section 4b: Complete this section if receiving COVID-19 vaccine	YES	NO
Have you ever been diagnosed with myocarditis or pericarditis?	☐	☐
Have you ever had Multisystem Inflammatory Syndrome (MIS-A or MIS-C)?	☐	☐
Has it been a minimum of 60 days since your last COVID-19 vaccine dose?	☐	☐
Section 4c: Complete this section if receiving HEPATITIS B vaccine	YES	NO
Is the person to be vaccinated receiving dialysis treatment?	☐	☐
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?	☐	☐
Section 4d: Complete this section if receiving MMR-II or VARICELLA vaccine	YES	NO
Do you have cancer, leukemia, HIV, or any other immune system problem	☐	☐
In the past 3 months, have you taken medication that affect you 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?	☐	☐
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?	☐	☐
Have you received any vaccinations in the past 4 weeks?	☐	☐

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 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, COVID-19 vaccination is recommended by the West Coast Health Alliance for anyone 6 months and older who chose protection and vaccination under these recommendations will be "off-label" use of currently licensed COVID-19 vaccines. **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