KODOCARE PHARMACY

2024 Vaccine Consent and Release Form

Vaccine(s) Requested: COVID-19 Flu RSV Pneumonia Shingles Tetanus (Tdap) Hepatitis A&B
(Please Circle) Other (Please Specify): ____________________

Last Name ____ **First Name** ____ **Middle Name** ____ **Date of Birth** __/__/__ **Age** ____ **Gender** M F Other

Address ____ **City** ____ **State** ____ **Zip** ____ **Phone Number** ( )____

Emergency Contact Name and Phone Number ____________________

Primary Care Provider Name and Phone Number ____________________

Race: American Indian/Alaskan Native Asian Black/African American Native Hawaiian/Other Pacific Islander White Other
Ethnicity: Hispanic or Latino Not Hispanic or Latino Decline to Answer Unknown

	Screening Questions – Please answer the following questions by checking the appropriate boxes	Yes	No
1.	Have you ever had a serious reaction such as anaphylaxis or fainting after receiving a vaccination?		
2.	Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs?		
3.	Do you have a bleeding disorder or are taking a blood thinner?		
4.	Do you have any allergies to medications, foods (example: eggs), latex or a vaccine component (example: gelatin, neomycin, polymyxin, yeast, thimerosal, etc.)? **If yes, please list:** ____		
5.	Do you have a long-term health problem such as heart disease, lung disease, liver disease, asthma, kidney disease, metabolic disease (example: diabetes), anemia, or other blood disorder? **If yes, please circle which applies to you.**		
6.	Have you had a seizure, or a brain or other nervous system problem, or Guillain-Barre?		
7.	During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?		
8.	Have you received any vaccinations in the past 4 weeks? **If yes, please list:** ____		
9.	**For Women**: Are you pregnant or is there a chance you could become pregnant in the next month?		
10.	**For COVID-19 Vaccination**: Have you tested positive for COVID in the last 90 days?		

Informed Consent: Please Read and Sign.

By my signature below, I consent to the administration of the vaccine(s) by a pharmacist or a supervised student pharmacist or technician, or other authorized person, where permitted by law or state/federal guidance, employed or contracted by KODOCARE Pharmacy and to be contacted at the number provided above regarding other immunizations for which I am due or eligible to receive. The above information is true and correct. I attest I meet eligibility criteria for the vaccination (if any); if I am the parent/guardian of the minor patient, I attest the minor patient meets eligibility criteria for the vaccination. I also release KODOCARE Pharmacy and its subsidiaries, affiliates, officers, directors, employees, and agents from all liability, including acts of omission or commission, resulting, or arising from my receipt or the minor's receipt of this vaccination. I understand that: 1) I have voluntarily chosen to receive the vaccination and understand that I am obligated to pay for all products and services received, if applicable. 2) I may be responsible for payment after the date of service if the product or service is billed to my insurance benefit. 3) I am of legal age and authorized to execute this consent form or I am the parent/guardian of the minor patient. 4) I will immediately alert the pharmacist of any medical conditions which may adversely affect my personal health or effectiveness of the vaccine. 5) I have been counseled about potential side effects after vaccination, when they may occur, and when and where I should seek treatment. I am responsible for following up with my physician at my expense if I experience any side effects. 6) I should remain in the area for observation for 15 minutes unless I have a history of an immediate allergic reaction of any severity to a vaccine or injectable therapy or if I have a history of anaphylaxis due to any cause I should remain in the area for observation for 30 minutes after the vaccination. If I leave the area without waiting, I acknowledge that I am doing so at my own risk and against the advice of the professional who administered the vaccine. 7) I have read, or have had read to me, the Vaccine Information Statement(s) ("VIS") provided for the vaccine(s) to be administered. I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction. I understand the benefits and risks of the vaccine(s). 8) I acknowledge that this consent will expire in one year from the date I signed it. 9) This vaccination, including any vaccination granted additional privacy protections under state or federal law, is subject to reporting by my pharmacy or its business associate to an immunization registry, which may share my immunization data with others, and to my primary care physician, the authorizing physician, or the local Department of Health, if applicable, and I authorize these disclosures.

X ____________________ __/__/__

Signature of Patient or Parent/Guardian (If verbal, please write the name of the POA) **Date**

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*If Verbal Consent – Name and Title of Person Accepting Verbal Authorization

Vaccinator Use Only

Trial claim(s) ran by:_____

INS:__________________