THE KROGER CO. FAMILY OF PHARMACIES

VACCINE CONSENT FORM

(Internal/Off Site Clinic Information)

☐Phone/Fax Date: __/__/____	☐RPH/Tech Name: ________
☐Phone/Fax Time: _____AM/PM	☐Registry Date: __/__/_____

First Name:	MI:	Last Name:	
Home Phone: ( ) -	Date of Birth: / /	Age:	Gender:
Home Address:	City:	State:	Zip Code:
Primary Care Physician/Provider:	Provider Phone: ( ) -	Insurance Company:	
Cardholder Name & Date of Birth:	Cardholder ID:	Group Number:	

I WANT TO BE PROTECTED FROM THE FOLLOWING (*PLEASE CHECK ALL THAT APPLY*): ☐ FLU ☐ HEPATITIS A ☐ HEPATITIS B ☐ HPV ☐ *MEASLES/MUMPS/RUBELLA (MMR)** ☐ MENINGITIS ☐ PNEUMONIA ☐ SHINGLES ☐ TDAP ☐ *VARICELLA** ☐ OTHER (PLEASE SPECIFY):__________

	Please answer the following questions so we can assess the safety and the appropriateness of vaccination:	Yes	No
ALL VACCINES	1. Do you have a fever or illness today?		
	2. Do you have any allergies to medications, foods (e.g. eggs), latex, or a vaccine component (e.g. gelatin, neomycin, polymyxin, yeast, thimerosal, etc.)? If yes, please list what you are allergic to:________________________________		
	3. Have you ever had a serious reaction after receiving a vaccine? (swelling, trouble breathing, seizure, etc.)		
	4. Have you had the vaccine (s) you are receiving today before?		
	5. Have you experienced seizures, Guillain-Barre Syndrome, or any other neurological disorder?		
	6. Have you received any vaccines in the past 28 days? If yes, please list vaccine and date:__________________________		
	7. **For Women**: Are you currently pregnant, breastfeeding, or are you planning to become pregnant in the next month?		
**LIVE VACCINES*	8. Do you have cancer, leukemia, lymphoma, HIV/AIDS, organ transplantation, or any other immune system problem?		
	9. In the past 3 months, have you taken medications that weaken your immune system, such as anticancer drugs, high-dose steroids, chemotherapy, injectable therapy for rheumatoid arthritis, Crohn's disease or psoriasis (e.g. Humira, Enbrel) or had radiation treatments? If yes, list medication, dose, and date last taken:__________________________		
	10. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? If yes, list medication, dose, and date last taken:__________________________		

I hereby give my consent to the healthcare provider of The Kroger Co., its affiliates and subsidiaries,, to administer the vaccine(s) I have requested above. I understand the risks and benefits associated with the vaccine(s) being administered and have received, read and/or had explained to me the CDC's Vaccine Information Statement (VIS) on the vaccine(s) I have elected to receive. I have had the opportunity to ask questions that were answered to my satisfaction. As with all medical treatment, there is no guarantee that I will not experience an adverse reaction from the vaccine. I understand that the information contained on this form may be shared with the Stated Health Division (SHD) and/or state immunization registries, and will remain confidential and will not be released except as permitted or required by law. If eligible, I authorize Kroger to submit a claim for reimbursement on my behalf to Medicare or any other contracted third party payor. If the claim is denied, I understand that I will be responsible for payment. I acknowledge that I have received a copy of the Notice of Privacy Practices. **Furthermore, I agree to remain near the vaccination location for approximately 15-20 minutes after administration for observation by the administering healthcare provider.**

X____ **Date:** ________________

(SIGNATURE OF PATIENT OR LEGAL GUARDIAN, IF PATIENT UNDER AGE 18) (**FOR LEGAL GUARDIANS ONLY**: **PRINT NAME and RELATIONSHIP**)

*** FOR INTERNAL USE ONLY ***

Vaccine Name: ________________ Manufacturer: ________________ Dose:________Series #:_____of_____ Vaccine Lot #: ________________ Vaccine Exp. Date: _____________ Diluent Lot #/Exp. Date: __________	Vaccine Name: ________________ Manufacturer: ________________ Dose:________Series #:_____of_____ Vaccine Lot #: ________________ Vaccine Exp. Date: _____________ Diluent Lot #/Exp. Date: __________	Vaccine Name: ________________ Manufacturer: ________________ Dose:________Series #:_____of_____ Vaccine Lot #: ________________ Vaccine Exp. Date: _____________ Diluent Lot #/Exp. Date: __________
Injection Site: **LEFT/RIGHT; ARM/THIGH** Route: **IM** or **SubQ** VIS Given:_/__/__Version Date:_/__/__	Injection Site: **LEFT/RIGHT; ARM/THIGH** Route: **IM** or **SubQ** VIS Given:_/__/__Version Date:_/__/__	Injection Site: **LEFT/RIGHT; ARM/THIGH** Route: **IM** or **SubQ** VIS Given:_/__/__Version Date:_/__/__

Supervising RPh/Lic#: ______________________________ (if required)

Immunizer: ________________________RPH/Intern/NP/PA/LPN/RN Date Administered:__/__/___Time:_______AM/PM