Vaccine Consent and Documentation

Added to KSWebIZ electronically through ComputerRX

Pharmacy Name
Address | Phone Number

☐ Flu ☐ Covid ☐ Shingles ☐ Pneumonia ☐ Tetanus, Diphtheria, Pertussis (TDaP) ☐ Other _____

☐ RSV ☐ HPV ☐ Hepatitis-A ☐ Hepatitis-B ☐ Measles, Mumps, Rubella (MMR)

Patient Information

First Name	Last Name	Date of Birth	Age	Sex	
		/ /		**M**	**F**

Address	City	State	Zip

Primary Care Physician	Patient Phone Number

Screening Questions

Do you have a fever or illness today?	☐ YES	☐ NO
Do you have a long-term health problem with heart disease, kidney disease, diabetes, or blood disorder? (Pneumovax recommended age 19-64)	☐ YES	☐ NO
Do you smoke, have asthma, COPD, or emphysema? (Pneumovax recommended age 19-64)	☐ YES	☐ NO
Do you have cancer, leukemia, HIV/AIDS, or other immunocompromising condition?	☐ YES	☐ NO
Do you have allergies to any medications, eggs, vaccine components (e.g. diphtheria toxoid, gelatin, yeast, thimerosal, aluminum, etc), or latex?	☐ YES	☐ NO
If yes, please list:		
Have you ever had a serious reaction after receiving a vaccination (i.e. swelling, trouble breathing, or seizure)?	☐ YES	☐ NO
Have you experienced seizures, Guillain-Barre Syndrome, or other neurological problem?	☐ YES	☐ NO
FOR WOMEN: Are you currently pregnant or breastfeeding?	☐ YES	☐ NO

I have been offered a copy of the Vaccine Information Statement(s) (VIS) or Emergency Use Authorization (EUA) fact sheet(s). I have read, had explained to me, and understand the information in the VIS(s)/fact sheet(s). I ask that the vaccine(s) checked above be given to me or to the person named below for whom I am authorized to make this request.

X _____

SIGNATURE OF PATIENT OR PERSON AUTHORIZED FOR PATIENT DATE

Immunizer Signature			Title	Supervising RPH		Date of Immunization Given	
Vaccine Name	Lot	Exp Date	Diluent Lot/Exp	MFG	Site	Route	VIS Date
					LA RA	**IM SQ**	
					LA RA	**IM SQ**	