Covid Vaccine Screening and Consent Form

KinneyDrugs

Sections A-C to be completed by patient | Please complete the information below for your pharmacist to complete your immunization.

Patient Name: _____ **Date of Birth:** _____

SECTION A

☐ YES ☐ NO **Vaccine You are Receiving Today: COVID-19 Vaccine**

☐ YES ☐ NO **Are you feeling sick today or do you have a moderate fever?**

☐ YES ☐ NO **Have you received a transfusion of blood or blood products, or been given immune** (gamma) **globulin during the past year?**

☐ YES ☐ NO **Do you have a history of thrombocytopenia orthrombocytopenia purpura** (MMR II only)?

☐ YES ☐ NO **Have you received passive antibody therapy** (monoclonal antibodies or convalescent serum) **as treatment for COVID-19?**

☐ YES ☐ NO **Have you received another vaccine in the last 14 days?**

☐ YES ☐ NO **Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?**

☐ YES ☐ NO **Do you have a bleeding disorder or are you taking a blood thinner?**

☐ YES ☐ NO **Do you have allergies to medications, food components, vaccine components, or latex?** (Examples: eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast, thimerosal)

☐ YES ☐ NO **Do you have a chronic condition or long term health problem?** (Examples: heart disease, lung disease, asthma, kidney disease, diabetes, anemia, other blood disorders, or is the patient, a smoker?)

☐ YES ☐ NO **Have you ever had a serious reaction after receiving an immunization?**

☐ YES ☐ NO **Have you ever had a seizure disorder, brain disorder, or Guillain-Barre Syndrome, or nervous system problems?**

☐ YES ☐ NO **Are you currently pregnant, considering becoming pregnant in the next month, or breast-feeding**

☐ YES ☐ NO **Have you received any vaccinations or skin tests in the past four weeks?**

☐ YES ☐ NO **Do you have a weakened immune system or have been in contact with anyone with a severely weakened immune system?** (Examples: cancer, leukemia, lymphoma, HIV/AIDS, transplant or any other immune system disorder)

☐ YES ☐ NO **Are you currently on home infusions, weekly injections, steroid therapy, anticancer drugs, antivirals or radiation treatment?**

SECTION B *Consent*

I certify that I am: (a) the patient and at least 18 years of age; or (b) the legal guardian of the patient. Further, I hereby give my consent to the certified-immunizing pharmacist, pharmacy intern (if permitted), registered nurse, licensed practical nurse, licensed vocational nurse, nurse practitioner, physician or physician assistant of KPH Healthcare Services, Inc., as applicable, to administer the vaccine(s) I have requested above. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine(s) and have received, read and had explained to me the Vaccine Information Statements on the vaccine(s) I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. Further, I acknowledge that I have been advised to remain near the vaccination location for approximately 15-30 minutes after administration for observation by the administering healthcare provider. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless KPH Healthcare Services, Inc., as applicable, its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above. I acknowledge that the administration of an immunization or vaccine does not substitute for an annual check-up with my primary care physician. I acknowledge receipt of KPH Healthcare Services, Inc.'s privacy notice for Protected Health Information. I acknowledge that (a) I understand the purposes/benefits of my state's immunization registry ("State Registry") and my state's health information exchange ("State HIE"); and (b) KPH Healthcare Services, Inc., as applicable, may disclose my immunization information to the State Registry, to the State HIE, or through the State HIE, to the State register, for purposes of public health reporting or to my health care providers enrolled in the State Registry and/or State HIE for purposes of care coordination. I acknowledge that, depending upon my state's law, I may prevent such disclosure, by using a state-approved opt-out form. Unless I provide KPH Healthcare Services, Inc. with a signed Op-Out Form, I understand that my consent will remain in effect until I withdraw my permission and that I may withdraw my consent by providing a completed Opt-Out Form to KPH Health Services, Inc. and/or my State HIE, as applicable. I understand that even if I do not consent or if I withdraw my consent, my state's laws may permit certain disclosures of my immunization information to or through the State HIE and/or my primary care provider listed above as required or permitted by law. I further authorize KPH Healthcare Services, Inc. to (a) release my medical or other information, including my communicable disease (including HIV), mental health and drug/alcohol abuse information, to, or through, the State HIE to my healthcare professions, Medicare, Medicaid, or other thirdparty payer as necessary to effectuate care or payment, (b) submit a claim to my insurer for the above requested items and services, and (c) request payment of authorized benefits be made on my behalf to KPH Healthcare Services, Inc., as applicable, with respect to the above requested items and services. I have been informed of the total cost of the immunization, subtracting any health insurance subsidization. I have been informed that if the immunization is not covered by my health insurance, that the immunization may be covered when administered by a primary care provider.

Signature (Patient or Guardian)**:** _____ **Date:** _____

SECTION C

Site: ☐ Right Deltoid ☐ Left Deltoid **Date of Immunization:** _____