THE KROGER CO. FAMILY OF PHARMACIES

NORTH CAROLINA VACCINE CONSENT FORM

LIVE AND INACTIVATED VACCINES

(Internal/Off Site Clinic Information)

☐Phone/Fax Date:__/__/__ ☐RPh/Tech Name:_____

☐Phone/Fax Time:____AM/PM ☐Registry Date: __/__/____

First Name:	MI:	Last Name:		Mother's Name: (first/maiden)	
Home Phone: ( ) -	Date of Birth: / /	Age:	Weight:	Gender:	Ethnicity:
Home Address:	City:	County:		State:	Zip Code:
Primary Healthcare Provider:	Provider Address:			Provider Phone: ( ) -	
Insurance Carrier:	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. Are you sick today?		
	2. Do you have any allergies to medications, food, yeast, a vaccine component, or latex? If yes, please list what you are allergic to:_____		
	3. Have you ever had a serious reaction after receiving a vaccination? (swelling, trouble breathing, seizure, etc.)		
	4. Has any physician or other healthcare professional cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a medical setting?		
	5. Do you have a long-term health problem such as heart disease, lung disease, liver disease, asthma, kidney disease, metabolic disease (e.g. diabetes), anemia, or other blood disorder?		
	6. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem? Have you been diagnosed with rheumatoid arthritis, ankylosing spondylitis, Crohn's disease?		
	7. In the past 3 months, have you taken medications that weaken your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?		
	8. Have you had a seizure or a brain or other nervous system problem or Guillain Barre?		
	9. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?		
	10. **For women**, are you pregnant or is there a chance you could become pregnant during the next month?		
	11. Have you received any vaccinations or TB skin test in the past 4 weeks? _____		
	12. Do you have a history of fainting, particularly with vaccines?		
	13. **For Tdap and adult Td.**, do you have a cut, injury, puncture or open wound that prompted you to get a tetanus shot?		
	14. **For Zoster**, have you had a past reaction to gelatin or triple antibiotic ointment?		
	15. Do you have any current medical conditions? If yes, please list your condition(s):_____		

**** An immunization must NOT be given if there is an affirmative answer to question 4 or 13, any other affirmative answers should have a clinical due diligence per protocol.***

I have read, or have read to me, the written information regarding the vaccine(s) I requested. I have had the opportunity to ask questions about the procedure, vaccine, or administration that was answered to my satisfaction. I understand the benefits and risks of the vaccine(s) being administered and I have received a copy of the Vaccine Information Statement (VIS). I, on behalf of myself, my heirs, executors, personal representatives, agents, successors, and assigns hereby agree to release and hold harmless Kroger Co., its subsidiaries, divisions, affiliates, agents, officers, directors, contractors, and employees from any and all claims arising out of, in connection with, or in any way related to the administration of the vaccine(s) requested. I understand that the information contained on this form may be shared with the State Health Division (SHD) and state immunization registries, and will remain confidential and will not be released except as permitted or required by law. If eligible, I ask that payment of authorized Medicare benefits be made on my behalf of Kroger Pharmacy for the vaccine(s) administered to me by Kroger Pharmacy. I am authorizing any holder of medical or other information about myself to be released to Centers for Medicare and Medicaid Services (CMS) and its agents, including any information needed to determine any and all benefits for related services. If Medicare Part B denies payment because a HMO plan is my primary then I will be responsible for payment upon denial from one of these payers**. I agree to wait near the vaccination location for approximately 15 minutes for observation by a pharmacist.**

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** or **RIGHT ARM** Route: **IM** or **SubQ** VIS Given:__/__/__Version Date:__/__/__	Injection Site: **LEFT** or **RIGHT ARM** Route: **IM** or **SubQ** VIS Given:__/__/__Version Date:__/__/__	Injection Site: **LEFT** or **RIGHT ARM** 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		

Confidentiality Notice: The information contained in this message may be privileged, confidential and protected from disclosure. If the reader of this message is not the intended recipient, or an employee or agent responsible for delivering this message to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by replying to this message and deleting it.