VACCINE CONSENT FORM

QFC/Fred Meyer

☐ Immunizer Name:	(Internal/Off Site Clinic Information)
☐ Phone/Fax Date:_____/_____/_____	
☐ Phone/Fax Time: ____:____ AM/PM	
☐ Registry Date: _____/_____/_____	

First Name:	MI:	Last Name:			
Home Phone: ( ) -	Date of Birth: / /	Age:	Weight:	Gender:	Ethnicity:
Home Address:	City:			State:	Zip Code:
Primary Healthcare Provider:	Provider Address:			Provider Phone/Fax: ( ) -	
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. Do you have any of the following symptoms today? Fever, cough, shortness of breath, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, diarrhea		
	2. In the past 14 days, have you had a fever or been exposed to or confirmed to have COVID-19, regardless of symptoms?		
	3. Have you had a physical examination by a healthcare provider in the last year?		
	4. 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:_____		
	5. Have you ever had a serious reaction after receiving a vaccine? (swelling, trouble breathing, seizure, etc.)		
	6. Have you had the vaccine (s) you are receiving today before?		
	7. Have you experienced seizures, Guillain-Barre Syndrome, or any other neurological disorder?		
	8. Have you received any vaccines in the past 28 days? If yes, please list vaccine and date:_____		
	9. **For Women**: Are you currently pregnant, breastfeeding, or are you planning to become pregnant in the next month?		
*LIVE VACCINES	10. Do you have cancer, leukemia, lymphoma, HIV/AIDS, organ transplantation, or any other immune system problem?		
	11. 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:_____		
	12. 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 health care 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.**

✘_____ **Date:** _____

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

*** FOR INTERNAL USE ONLY *** ☑**REQUIRED**: obtained verbal consent to treat prior to administration

Vaccine Name: Fluarix Quadrivalent	Vaccine Name:_____	Vaccine Name:_____
Manufacturer: GlaxoSmithKline	Manufacturer:_____	Manufacturer:_____
Dose: 0.5 mL Series #: 1 of 1	Dose:_____ Series #: ____ of ____	Dose:_____ Series #:_____ of _____
Vaccine Lot #: 9S4K5	Vaccine Lot #:_____	Vaccine Lot #:_____
Vaccine Exp. Date: 6/30/2021	Vaccine Exp. Date:_____	Vaccine Exp. Date:_____
Diluent Lot #/Exp. Date:_____	Diluent Lot #/Exp. Date:_____	Diluent Lot #/Exp. Date:_____
Injection Site: **LEFT/RIGHT; ARM/THIGH**	Injection Site: **LEFT/RIGHT; ARM/THIGH**	Injection Site: **LEFT/RIGHT; ARM/THIGH**
Route: **IM** or **SubQ**	Route: **IM** or **SubQ**	Route: **IM** or **SubQ**
VIS Given: 10 / 1 / 2020	VIS Given: ____/____/____	VIS Given: ____/____/____
Version Date: 08 / 15 / 2019	Version Date: ____/____/____	Version Date: ____/____/____

☑**REQUIRED**: counseled patient to remain near location for 15 to 20 mins Supervising RPh/Lic#: Brandon Thoreson / 12537 *(if required)*

Immunizer: RPH / INTERN Date Administered: 10 / 1 / 2020 Time: _____AM/PM

Substitution Permitted_____ Dispense as Written_____

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Influenza (Flu) Vaccine (Inactivated or Recombinant): *What you need to know*

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1 Why get vaccinated?

Influenza vaccine can prevent **influenza (flu)**.

Flu is a contagious disease that spreads around the United States every year, usually between October and May. Anyone can get the flu, but it is more dangerous for some people. Infants and young children, people 65 years of age and older, pregnant women, and people with certain health conditions or a weakened immune system are at greatest risk of flu complications.

Pneumonia, bronchitis, sinus infections and ear infections are examples of flu-related complications. If you have a medical condition, such as heart disease, cancer or diabetes, flu can make it worse.

Flu can cause fever and chills, sore throat, muscle aches, fatigue, cough, headache, and runny or stuffy nose. Some people may have vomiting and diarrhea, though this is more common in children than adults.

Each year **thousands of people in the United States die from flu**, and many more are hospitalized. Flu vaccine prevents millions of illnesses and flu-related visits to the doctor each year.

2 Influenza vaccine

CDC recommends everyone 6 months of age and older get vaccinated every flu season. **Children 6 months through 8 years of age** may need 2 doses during a single flu season. **Everyone else** needs only 1 dose each flu season.

It takes about 2 weeks for protection to develop after vaccination.

There are many flu viruses, and they are always changing. Each year a new flu vaccine is made to protect against three or four viruses that are likely to cause disease in the upcoming flu season. Even when the vaccine doesn't exactly match these viruses, it may still provide some protection.

Influenza vaccine **does not cause flu**.

Influenza vaccine may be given at the same time as other vaccines.

3 Talk with your health care provider

Tell your vaccine provider if the person getting the vaccine:

- Has had an **allergic reaction after a previous dose of influenza vaccine**, or has any **severe, life-threatening allergies**.
- Has ever had **Guillain-Barré Syndrome** (also called GBS).

In some cases, your health care provider may decide to postpone influenza vaccination to a future visit.

People with minor illnesses, such as a cold, may be vaccinated. People who are moderately or severely ill should usually wait until they recover before getting influenza vaccine.

Your health care provider can give you more information.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

4 Risks of a vaccine reaction

- Soreness, redness, and swelling where shot is given, fever, muscle aches, and headache can happen after influenza vaccine.
- There may be a very small increased risk of Guillain-Barré Syndrome (GBS) after inactivated influenza vaccine (the flu shot).

Young children who get the flu shot along with pneumococcal vaccine (PCV13), and/or DTaP vaccine at the same time might be slightly more likely to have a seizure caused by fever. Tell your health care provider if a child who is getting flu vaccine has ever had a seizure.

People sometimes faint after medical procedures, including vaccination. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

5 What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call **9-1-1** and get the person to the nearest hospital.

For other signs that concern you, call your health care provider.

Adverse reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your health care provider will usually file this report, or you can do it yourself. Visit the VAERS website at **www.vaers.hhs.gov** or call **1-800-822-7967**. *VAERS is only for reporting reactions, and VAERS staff do not give medical advice.*

6 The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines. Visit the VICP website at **www.hrsa.gov/vaccinecompensation** or call **1-800-338-2382** to learn about the program and about filing a claim. There is a time limit to file a claim for compensation.

7 How can I learn more?

- Ask your healthcare provider.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636** (**1-800-CDC-INFO**) or
  - Visit CDC's **www.cdc.gov/flu**