Vaccine Administration Record

Kinney DRUGS™ PROACT INC. A PHARMACY BENEFITS MANAGEMENT COMPANY HEALTHDIRECT INSTITUTIONAL PHARMACY SERVICES

STORE STAMP

First name: _____ **Last name:** _____ **Date of birth:** _____

Insurance Billing Information:

Cardholder Name: _____ **Insurance Name:** _____

Bin: _____ **PCN:** _____ **ID:** _____ **Group Number:** _____

***For patients without a PCP:** I have provided oral and written information about the importance of having a Medical Home. RPh Initials: _____

***RPh Only:** I have reviewed the Vaccine Screening Questionnaire to assess patient for potential contraindications and precautions to the vaccines being administered today. RPh Initials: _____

*For Patients ≥65 yrs of age document Medicare card information and obtain a signed AOB on ALL patients. RPh Initials: _____

Area below to be completed by Immunizing Pharmacist

Influenza

Manufacturer:	
Brand Name:	
Lot#:	
Expiration Date:	
Dose and Route: ☐ 0.5 ML IM ☐ 0.2 ML Intranasally	
Site: ☐ Nasal ☐ Right Deltoid ☐ Left Deltoid	
Date on VIS:	Date VIS Given:

Pneumococcal

Manufacturer:	
Brand Name:	
Lot#:	
Expiration Date:	
Dose and Route: ☐ 0.5 ML IM	
Site: ☐ Left ☐ Right Deltoid	
Date on VIS:	Date VIS Given:

Herpes Zoster

Manufacturer:	
Brand Name:	
Lot#:	
Expiration Date:	
Dose and Route: ☐ 0.5 ML IM	
Site: ☐ Left ☐ Right Arm	
Date on VIS:	Date VIS Given:

Tdap or Td

Manufacturer:	
Brand Name:	
Lot#:	
Expiration Date:	
Dose and Route: ☐ 0.5 ML IM	
Site: ☐ Left ☐ Right Deltoid	
Date on VIS:	Date VIS Given:

Vaccine:

Manufacturer:	
Brand Name:	
Lot#:	
Expiration Date:	
Dose:	Route: ☐ IM ☐ SQ ☐ Oral
Site: ☐ Left ☐ Right	
Date on VIS:	Date VIS Given:

Vaccine:

Manufacturer:	
Brand Name:	
Lot#:	
Expiration Date:	
Dose:	Route: ☐ IM ☐ SQ ☐ Oral
Site: ☐ Left ☐ Right ☐ IM ☐ SQ	
Date on VIS:	Date VIS Given:

Signature of Immunization RPh:	RPh License#:
Date of Immunization:	Address of Immunization (If different than store address):

Vaccine Screening and Informed Consent Form

TO BE COMPLETED BY PATIENT

Kinney DRUGS™ PROVACT INC. A PHARMACY BENEFITS MANAGEMENT COMPANY HEALTHDIRECT INSTITUTIONAL PHARMACY SERVICES

STORE STAMP

SECTION A *(Please print clearly.)*

Name: _____ **Date of birth:** _____ **Age:** _____ **Mother's Maiden Name:** _____

Gender: ☐ Female ☐ Male **Do you weigh <110lbs?** ☐ Yes ☐ No **Phone:** _____

Home address: _____ **City:** _____ **State:** _____ **ZIP code:** _____

Primary care provider name: _____ **Phone number:** _____

Address: _____ **City:** _____ **State:** _____ ☐ I do not have a primary care doctor/provider

I want to receive the following immunization(s):

☐ Flu (influenza) ☐ Pneumonia (pneumococcal) ☐ Shingles (herpes zoster) ☐ Tdap (whooping cough) ☐ Other: _____

SECTION B *The following questions will help us determine your eligibility to be vaccinated today. For all vaccines: Please answer questions 1-7. For live vaccines (e.g., MMR or shingles): Please answer questions 1-13. For flu nasal spray: Please answer questions 1-15.*

All vaccines				
1.	Are you currently sick?	☐ Yes	☐ No	☐ Don't know
2.	Have you ever fainted or felt dizzy after receiving an immunization?	☐ Yes	☐ No	☐ Don't know
3.	Have you ever had a reaction after receiving an immunization?	☐ Yes	☐ No	☐ Don't know
4.	Do you have an immunocompromising condition (e.g., cancer, leukemia, lymphoma, HIV/AIDS, transplant), functional or anatomic asplenia, CSF leak or cochlear implant?	☐ Yes	☐ No	☐ Don't know
5.	Do you have allergies to latex, medications, food or vaccines? (Examples: eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal) a. If yes, please list: _____	☐ Yes	☐ No	☐ Don't know
6.	Have you ever had a seizure disorder for which you are on seizure medications, a brain disorder, Guillain-Barré syndrome or other nervous system problems?	☐ Yes	☐ No	☐ Don't know
7.	**For women:** Are you pregnant or considering becoming pregnant in the next month?	☐ Yes	☐ No	☐ Don't know
Live vaccines (Chicken pox, flu nasal spray, MMR, oral typhoid, shingles) Only answer these questions if you are receiving any immunization listed above.				
8.	Are you currently on home infusions, weekly injections (such as adalimumab, infliximab and etanercept), high-dose methotrexate, azathioprine or 6-mercaptopurine, antivirals, anticancer drugs or radiation treatments?	☐ Yes	☐ No	☐ Don't know
9.	Have you received any vaccinations or skin tests in the past four weeks? a. If yes, please list: _____	☐ Yes	☐ No	☐ Don't know
10.	Have you received a transfusion of blood, blood products or been given a medication called immune (gamma) globulin in the past year?	☐ Yes	☐ No	☐ Don't know
11.	Are you currently taking high-dose steroid therapy (prednisone >20mg/day or equivalent) for longer than two weeks?	☐ Yes	☐ No	☐ Don't know
12.	Are you currently taking any antibiotics or antimalarial medications? (Oral typhoid only)	☐ Yes	☐ No	☐ Don't know
13.	Do you have a history of thrombocytopenia or thrombocytopenic purpura? (MMR only)	☐ Yes	☐ No	☐ Don't know
Flu nasal spray (FluMist® Quadrivalent)				
14.	For patients 18 years of age, are you receiving aspirin therapy or aspirin-containing therapy?	☐ Yes	☐ No	☐ Don't know

SECTION C

I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient. Further, I hereby give my consent to the certified-immunizing pharmacist 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. Also, if I do not have a primary care provider, I have been given oral and written information about the importance of having a Medical Home. **Further, I acknowledge that I have been advised to remain near the vaccination location for approximately 15 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: (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 Registry, 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, by using a state-approved opt-out form which will be provided to me upon request from KPH Healthcare Services, Inc.: (a) the disclosure of my immunization information by KPH Healthcare Services, Inc., to the State HIE and/or State Registry; or (b) the State HIE and/or State Registry from sharing my immunization information with any of my other healthcare providers enrolled in the State Registry and/or State HIE. I understand that, depending on my state's law, I may need to specifically consent, and to the extent required by my state's law, by signing below, I hereby do consent to KPH Healthcare Services, Inc., as applicable, reporting my immunization information to the State HIE, or through the State HIE and/or State Registry to the entities and for the purposes described in this Informed Consent form. Unless I provide KPH Healthcare Services, Inc., as applicable, with a signed Opt-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 Healthcare 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., as applicable, 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 professionals, Medicare, Medicaid, or other third-party 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 further agree to be fully financially responsible for any cosharing amounts, including copays, coinsurance, and deductibles, for the requested items and services as well as for any requested items and services not covered by my insurance benefits. I understand that any payment for which I am financially responsible is due at the time of service or, if KPH Healthcare Services, Inc., invoices me after the time of service, upon receipt of such invoice.**

Signature: _____ **Date:** _____

(Patient or Guardian)