

**SECTION A** (Please print clearly)

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ Mother's maiden name: \_\_\_\_\_

Gender:  Female  Male Do you weigh under 110lbs?:  Yes  No Phone: \_\_\_\_\_

Home address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP code: \_\_\_\_\_

**Insurance Information**

Name of Policy Holder: \_\_\_\_\_

Insurance name: \_\_\_\_\_

ID number: \_\_\_\_\_ Rx Group number: \_\_\_\_\_

BIN number: \_\_\_\_\_ PCN: \_\_\_\_\_ Last 4 digits of SSN (if Medicare eligible): \_\_\_\_\_

For non-COVID -19 vaccines I agree to be fully financially responsible for any co-sharing 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.

Patient initials \_\_\_\_\_ Primary care provider name: \_\_\_\_\_ Phone number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_  I do not have a primary care doctor



Please add Buzzy to my vaccination. (Buzzy is a sting-free option for your vaccine. It's FREE! Ask your pharmacist!)  Yes  No  Tell me more

**SECTION B** Please complete the following questions for you or the person being vaccinated, to us determine your eligibility to be vaccinated.

**All vaccines**

1. Are you sick today?  Yes  No  Don't know
2. Have you ever fainted or felt dizzy after receiving an immunization?  Yes  No  Don't know
3. Do you have allergies to medications, food, a vaccine or component, or latex?  Yes  No  Don't know
4. Have you ever had a reaction after receiving an immunization?  Yes  No  Don't know
5. Do you have a history of myocarditis (inflammation of the heart muscle), pericarditis (inflammation of the lining of the heart), or multisystem inflammatory syndrome (MIS)?  Yes  No  Don't know
6. Do you have cancer, leukemia, HIV/AIDS or any other condition that weakens the immune system?  Yes  No  Don't know
7. Do you take any medications that affect your immune system, such as cortisone, prednisone or other steroids, or anti-cancer drugs, or have you had any radiation treatments?  Yes  No  Don't know
8. Have you ever had a seizure disorder for which you are on seizure medications, a brain disorder, Guillain-Barre syndrome or other nervous system problems?  Yes  No  Don't know
9. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), or anemia or other blood disorder?  Yes  No  Don't know
10. Have you received a transfusion of blood or blood products or been given a medication called immune (gamma) globulin in the past year?  Yes  No  Don't know
11. For Women: Are you pregnant or considering becoming pregnant in the next month?  Yes  No  Don't know

**SECTION C** 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 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 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 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. **Emergency Use Authorization for COVID Only** - The FDA has made the COVID-19 vaccine available under an emergency use authorization (EUA). The EUA is used when circumstances exist to justify the emergency use of drugs and biological products during an emergency, such as the COVID-19 pandemic. This vaccine has not undergone the same type of review as an FDA-approved or cleared product. However, the FDA's decision to make the vaccine available is based on the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks. Please note: FDA approved the Pfizer-BioNTech COVID-19 vaccine as a two-dose series in individuals 16 years of age and older. The vaccine continues to be available under an EUA for certain populations, including for those individuals 5 through 15 years of age and for the administration of a third dose in the populations set forth in the consent section below.

Date: \_\_\_\_\_

Name of Legal Parent or Guardian (print): \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Signature: (Patient or Legal Guardian):

SIGN IN BOX BELOW

