# Flu Clinic Screening and Informed Consent Form

Sections A-C to be completed by patient

KinneyDrugs

## 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:** _____

### Insurance Information

**Insurance Name:** _____

**Name of Policy Holder:** _____

**ID number:** _____ **Group number:** _____

**BIN number:** _____ **PCN:** _____

*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*

## SECTION B *The following questions will help us determine your eligibility to be vaccinated today.*

### 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?** (e.g., eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal) | ☐ Yes ☐ No ☐ Don't know |
| 6. | **Have you ever had a seizure disorder for which you are on seizure medications, a brain disorder, Guillain-Barre syndrome ore other nervous system problems?** | ☐ Yes ☐ No ☐ Don't know |
| 7. | **Do you have a long term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease** (e.g., diabetes)**, anemia or other blood disorder?** | ☐ Yes ☐ No ☐ Don't know |
| 8. | **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.*

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

## SECTION D

***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 contraindictions 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** _____

### Influenza

**Manufacturer:** _____ **Brand name:** _____ **Lot#:** _____ **Expiration date:** _____

**Dose and Route:** ☐ 0.5 ML IM **Site:** ☐ Right Deltoid ☐ Left Deltoid **Date on VIS:** _____ **Date VIS given:** _____

**Signature** of Immunizations RPh**:** _____ **RPh License#:** _____

**Name of Flu Clinic:** _____ **Date of Immunization:** _____ **Address of Immunization:** _____