KATTERMAN'S PHARMACY IMMUNIZATION CONSENT FORM

5400 Sand Point Way NE Seattle, WA 98105 | (206) 524-2211 | Steve Cone & Beverly Schaefer, Pharmacists

Last Name: ______________________ **First Name:** ______________________ **Birth Date:** ____ / ____ / ____ **Age:** _____ **Sex: M / F**

Address: ______________________________ **State:** _____ **Zip:** ___________ **Cell:** ______________________

Allergies: ______________________________ **Conditions:** ______________________________

Insurance Information

Attach your insurance card(s) to the clipboard if you are new to our pharmacy or if you have new insurance. If we have your insurance information on file, skip this section.

Medicare Part B		**Commercial Insurance**			
ID Number:	*(If ID# unknown)* **Last 4 digits of SSN:**	**RxBin**	**PCN**	**ID**	**RxGroup**

Screening Questions

General Screening (All Vaccines)	YES	NO
Are you Sick today?		
Have you ever felt dizzy, fainted, or had a serious reaction after a vaccine?		
Are you pregnant or planning to become pregnant?		

Live Vaccine Screening	YES	NO
Do you have a weakened immune system because of a condition (e.g, Cancer, HIV/AIDS, etc.), or treatment that affects the immune system (e.g., high-dose corticosteroids, cancer treatments, etc.)?		
Have you received any Live vaccinations or antibiotics in the past 4 weeks? (*examples listed below and denoted with a *)*. If unsure, name them: ______________________		
Do you have heart, lung, kidney, a metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, a cochlear implant, a spinal fluid leak, or are you on long-term aspirin therapy?		

Vaccines

*Mark vaccine(s) wanted. | * denotes a Live Vaccine which requires completion of "Live Vaccine Screening" section above. | For vaccine information, refer to the back of the form or speak to a pharmacist.*

Flu (Influenza):
- ☐ Flucelvax (6mo+) ☐ Fluad (65y+)
- ☐ Flumist* (intranasal) (ages 2-49y)
- ☐ Flublok (18y+) (Egg-Allergy / immunocompromised)

Covid:
- ☐ SpikeVax [Moderna] (12y+)
- ☐ Moderna [kids] (ages 6mo-12y)

Chikungunya:
- ☐ Ixchiq* (18y+)

Cholera:
- ☐ Vaxchora* (2-64y)

Hepatitis A:
- ☐ Havrix 1440 UNITS (19y+)
- ☐ Havrix 720 UNITS (12mo-18y)

Hepatitis B:
- ☐ Engerix 20 MCG (20y+)
- ☐ Engerix 10 MCG (0-19y)
- ☐ Heplisav (18y+)

Hepatitis A/B:
- ☐ Twinrix (18y+)

Hib (Haemophilus Influenzae type B)**:**
- ☐ ACTHIB (0-18mo)

HPV (Human Papillomavirus)**:**
- ☐ Gardasil 9 (9-45y)

Japanese Encephalitis:
- ☐ Ixiaro 0.5ml (3-18y) ☐ Ixiaro 0.25ml (2mo-3y)

Meningitis (Meningococcal)**:**
- ☐ Menquadfi (Type A,C,W,Y) (9mo-55y)
- ☐ Menveo (Type A,C,W,Y) (2mo-55y)
- ☐ Bexsero (Type B) (10-25y)
- ☐ Penbraya (Type A,B,C,W,Y) (10-25y)

Measles, Mumps, Rubella:
- ☐ M-M-R* (1y+)

Pneumonia:
- ☐ Prevnar 13 (6wk+) ☐ Prevnar 20 (6wk+)
- ☐ Pneumovax 23 (2y+)

Polio:
- ☐ IPOL (6wk+)

Rabies:
- ☐ RabAvert (Pre-Exposure) (all ages)
- ☐ RabAvert (Post-Exposure) (all ages)

RSV (Respiratory Syncytial Virus)**:**
- ☐ mRESVIA (60y+)
- ☐ Abrysvo (60y+ or 32-36wks pregnant)

Shingles:
- ☐ Shingrix (50+)

Tick-Borne Encephalitis:
- ☐ Ticovac 2.4 mcg (16+ yr)
- ☐ Ticovac 1.2 mcg (1-15 yr)

TDAP/DTaP (Tetanus, Diphtheria, and Pertussis)**:**
- ☐ Boostrix (10y+)
- ☐ DTaP (2-10y))

TD (Tetanus and Diphtheria Toxoids)**:**
- ☐ TDVax (7y+)

Typhoid Fever:
- ☐ Vivotif* (Oral) (6y+) ☐ Typhim (IM) (2y+)

Varicella (Chicken Pox)**:**
- ☐ Varivax* (12m+)

Yellow Fever:
- ☐ YF-Vax* (9mo+)

Other(s)______________________

Please review the following legal statements and vaccine information sheets on the back of this page before signing below.

By signing below, I certify that I have read, understood, and agreed to all statements on the back of this page and that either (a) I am the Patient, and at least 18 years old, and do not have a guardian, or (b) I am the Patient's parent/guardian with authority to consent and agree on behalf of the Patient.

______________________ ______________________ ______________

PATIENT / GUARDIAN NAME (PRINT) **PATIENT / GUARDIAN SIGNATURE** **DATE**

For Pharmacy Use: **Rx Hard Copy Authorization for Vaccines Chosen Above** Date: ____________

Prescribing PharmD: ______________________ Administrator (IF DIFFERENT FROM PRESCRIBING PharmD): ____________

Vaccine	Refills	Directions	Quantity	Frequency	Route	Site	Lot/Exp/Manufacturer	
________	_____	Inject | Take	0.25 mL | 0.5 mL | 1 mL | 1 cap	Once | QoD	IM | SubQ | PO | Nasal	_____	On Backtag	____________ SUBSTITUTION PERMITTED
________	_____	Inject | Take	0.25 mL | 0.5 mL | 1 mL | 1 cap	Once | QoD	IM | SubQ | PO | Nasal	_____	On Backtag	
________	_____	Inject | Take	0.25 mL | 0.5 mL | 1 mL | 1 cap	Once | QoD	IM | SubQ | PO | Nasal	_____	On Backtag	____________
________	_____	Inject | Take	0.25 mL | 0.5 mL | 1 mL | 1 cap	Once | QoD	IM | SubQ | PO | Nasal	_____	On Backtag	DISPENSE AS WRITTEN
________	_____	Inject | Take	0.25 mL | 0.5 mL | 1 mL | 1 cap	Once | QoD	IM | SubQ | PO | Nasal	_____	On Backtag	

For purposes of this consent, "I," "me," "my," "you," and "your," refer to the consent-giver or the Patient as a context requires. The consent-giver must be the Patient if the Patient possesses the legal capacity to consent (e.g., is not an unemancipated minor). Alternatively, the consent-giver must be an individual with the legal capacity to consent for the Patient such as a parent, legal guardian, or authorized healthcare surrogate.

I voluntarily request and consent that a Katterman's Pharmacy Vaccine Provider administer the selected vaccine(s) to the Patient. I understand the Katterman's Pharmacy Vaccine Provider is either a pharmacist, pharmacy intern, or pharmacy technician, employed or contracted by Katterman's Pharmacy.

I understand that Katterman's Pharmacy is providing necessary vaccines to the Patient in a safe and convenient setting to promote adherence to current immunization guidelines recommended by the CDC and ACIP and does not take the place of an ongoing relationship with the Patient's primary care provider to address ongoing medical issues and other types of preventative care. I understand that Katterman's Pharmacy is reporting all pertinent information of the vaccines administered to WAIIS such that the Patient's primary care provider's records and the Patient's medical records may be complete, but I will be sure to take the Patient's personal records to the Patient's next appointment as well.

I have truthfully answered all the questions regarding the Patient's medical history that are listed above. I understand that if I answered a question with a "yes" there is an increased likelihood that the Patient will experience an adverse reaction from the administration of the vaccine(s).
I have read, had explained to me, or opted to disregard the VISs [Vaccine Information Statement(s)], emergency use authorization(s), or applicable fact sheet(s) for the vaccine(s) as provided on the back of this form. Further, I acknowledge that if I was unable to access the VISs on the back of this form, that I had the opportunity to request a physical copy of said VIS(s) or request that the information be provided to me verbally by a pharmacist. As such, I understand the risks and benefits and will be/have been provided an opportunity to ask questions which have or will be answered to my satisfaction prior to the Patient's receipt of requested vaccine(s).

After careful consideration, I believe that the benefits of the Patient receiving the vaccine(s) outweigh the risks associated with receiving the vaccine(s), and I have decided to allow the Katterman's Pharmacy Vaccine Provider to administer the vaccine(s) to the Patient. By allowing the Katterman's Pharmacy Vaccine Provider to physically administer the vaccine to the Patient, I agree that I fully understand all the risks and benefits in connection with the vaccine and that all of my questions have been answered to my satisfaction, and I wish for the Patient to receive the vaccine and hereby give consent for the Katterman's Pharmacy Vaccine Provider to administer the vaccine.

I have provided true, complete, and accurate information identifying the Patient's applicable Healthcare plans/insurance coverage, if any. I authorize Katterman's Pharmacy to submit a claim to the Patient's healthcare plan/insurance for this service and hereby sign the Patient's rights to the healthcare plan/insurance benefits to collect any available benefits due with respect to such claim to Katterman's Pharmacy, its affiliates, or its subsidiaries. I will be financially responsible for any copays, coinsurance and deductibles for the requested services as well as for any services not covered by the Patient's Healthcare plan/insurance benefits.

I authorize Katterman's Pharmacy to use and/or disclose such information about the Patient, including any medical-related information that I provide to Katterman's pharmacy, it's affiliate, or it's subsidiary, or that is created or received by Katterman's pharmacy, it's affiliate, or it's subsidiary, that Katterman's Pharmacy reasonably determines is necessary to receive payment for its services, carry out treatment for the Patient, or conduct healthcare operations. This authorization includes disclosures to regulatory Agencies, Medicare, Medicaid, health plans, insurers, pharmacy benefit managers, claims processors, billing companies, interpreters, and other persons involved in the Patient's treatment or payment for the Patient's treatment, as well as any federal or state immunization registry, health information exchange, or adverse event database, or any designee for public health reporting or care coordination period depending on applicable law, I may prevent the disclosure of certain vaccination information to the registration or exchange by completing an opt-out form that's available in the pharmacy. I understand that even if I do not consent or if I withdraw my consent, applicable law may permit certain disclosures of my vaccination information to or through the registry or exchange or to government agencies.

Katterman's Pharmacy shall not at any time, or to any extent allowable by applicable law, be liable, responsible, or in any way accountable for any loss, injury, death, or damage suffered or sustained by the Patient or me or any other person at any time in connection with, or as a result of, the administration of vaccine(s) to the Patient by the Katterman's Pharmacy vaccine provider. I, for myself and for the Patient, and for my and the Patient's heirs, executors, personal representatives, and assigns, hereby release Katterman's Pharmacy, its affiliates and subsidiaries, and the employees and contractors (including specifically, without limitation, the administering Katterman's Pharmacy vaccine provider) as well as Katterman's Pharmacy and its affiliates' and subsidiaries' agents and representatives from any and all claims arising out of or in any way related to the Patient's receipt of a vaccine as and to the full extent allowed by applicable law.

Vaccine Information Sheets (VIS)

VISs can be accessed with the following QR Codes. If you are unable to access the forms, please speak with a pharmacist.

Vaccine VISs
https://www.cdc.gov/vaccines/hcp/vis/current-vis.html

Moderna Covid-19 Emergency Use Authorization (EUA)
https://www.fda.gov/media/144638/download

Travel Consultations

Unsure of what travel vaccines are recommended for your trip abroad? Book a consultation using the QR Code below, or visit Kattermans.com. You can also refer to the Center for Disease Control's (CDC) vaccine recommendations.

Travel Consultation Sign-Up
https://kattermans.com/travel-consults/

CDC Travel Vaccine Recommendations
https://wwwnc.cdc.gov/travel