University of Kentucky Vaccination Consent Form and Prescription

Patient Name:	SSN:	Medical Conditions:			
Cell Phone:	Date of Birth:	Age:	Gender:		Weight:
Home Address:	City:		State:		Zip Code:
Insurance Carrier:	Cardholder ID:		BIN:	PCN:	Group Number:
Circle Appropriately: UK HealthCare employee / UK Campus Employee / UK Student		UK ID:			Traditional Part B insurance: Yes / No

Vaccinations are automatically reported to Kentucky providers through the UK system and the KYIR. If you still need individual reporting for your primary care provider, please take a picture of the form AFTER vaccination or provide name and phone below:
Primary Care Provider/Phone Number: _____ Date/form of contact: _____ Staff:_____

I WANT PROTECTION FROM (CIRCLE ALL THAT APPLY): Flu, Hepatitis A, Hepatitis B, Pneumonia, HPV, Meningitis, Tetanus/ Diphtheria/Pertussis, Tetanus Booster, H. Flu (Hib), Measles/Mumps/Rubella (MMR), Shingles, Varicella, Rabies, COVID-19, Rotavirus, Polio, Smallpox, Mpox, Yellow Fever, Typhoid Fever, Japanese Encephalitis, Cholera, RSV, Tick-Borne Encephalitis, Dengue, Chikungunya

ALL VACCINES – Please ask your pharmacist if any questions arise	**Yes**	**No**	**Explain if answered Yes**
Are you sick today, have a fever, a rash or Shingles?			
Do you have allergies to ANY medication, food (e.g., eggs), latex or any vaccine component (e.g.neomycin, formaldehyde, gentamicin, thimerosal, bovine protein, phenol, polymyxin, gelatin, baker's yeast or yeast)?			
Have you ever had a serious reaction after receiving a vaccination?			
Have you had the vaccine (s) you are receiving today before? Vaccine/Date_____			
Have you received any vaccinations or skin tests in the past 4 weeks?			
Have you had seizures, Guillain-Barre Syndrome (GBS), or any neurological or brain disorder?			
Are you pregnant, breastfeeding or do you plan on becoming pregnant in the next three months?			
Are you a cigarette smoker or have Diabetes, Alcoholism or low immune system, Cerebrospinal fluid leak or Cochlear implant, Chronic heart, liver, or lung disease. (For Pneumonia vaccines)			
Do you have HIV/AIDS, organ transplant or bone marrow transplant, cancer, leukemia, lymphoma, multiple sclerosis, hematopoietic stem cell or any other immune system problem?			
LIVE VACCINES: Zostavax, MMR, LAIV, Varicella, Yellow Fever			
Are you taking any medications that weaken the immune system? A few examples: steroids (e.g. cortisone, prednisone), azathioprine, 6-mercaptopurine, methotrexate, cancer or radiation treatment, transplant drugs, therapy for rheumatoid arthritis, Crohn's disease, or psoriasis.			
During the past year, have you received a transfusion of blood or blood products, including plasma/platelet product, or been given an antiviral drug or immune (gamma) globulin?			
Do you have a history of thrombocytopenia or thrombocytopenia purpura? (for MMR II)			

All the information provided is correct to the best of my knowledge. I authorize the following: the release of any medical or other information with respect to this vaccine to my healthcare providers, Medicare, Medicaid, or other third-party payer as needed, and I request payment of authorized benefits to be made on my behalf to UK HealthCare Pharmacy Services. If my insurance does not cover the cost of administering the vaccine at the pharmacy, then payment must be made at the time of the administration of the vaccine or a bill can be sent to me and I agree to pay according to the credit terms of the pharmacy. I acknowledge that my vaccination record may be shared with federal or state agencies for registry reporting; and that the pharmacist recommends remaining in the waiting area for 20 minutes after receiving the vaccine. **If doing curbside/drive-thru vaccination where available, I understand it is still recommended to remain nearby for 20 minutes and to quickly notify the pharmacy staff of any reactions.** I have had the opportunity to ask questions that were answered to my satisfaction and understand the benefits and risks of the vaccine(s). I consent to, or give consent for, the administration of the vaccine(s). I fully release and discharge UK Healthcare Pharmacy Services, it affiliates, their officers, directors, and employees from any liability for illness, injury, loss, or damage that may result therefrom. **I have read or have had read to me the Vaccination Information Sheet (VIS) regarding the vaccine(s), and I hereby acknowledge receipt of the vaccines shown below. If I am a new patient to UK HealthCare, I acknowledge that I have received the Notice of Privacy Practices.**

X_____ **Date/Time**: _____
(SIGNATURE OF PATIENT IF 18 YEARS OLD AND ABOVE, OR LEGAL REPRESENTATIVE AND RELATIONSHIP)

X_____
PRINTED NAME OF PERSON SIGNING ABOVE

Interpreter Name or ID# _____
In Person of Via Cyracom (Circle One)

*****FOR INTERNAL USE ONLY*****

Vaccine: _____ Sig: _____ Qty: _____ Series#___ of ___	Vaccine: _____ Sig: _____ Qty: ____ Series#___ of ___	Vaccine: _____ Sig: _____ Qty: ____ Series#___ of ___

Provider: Stakelin, Kristen **(Not valid if patient is < 5YO)** DEA: BS5894971 Date Written:_____
Provider: _____Address_____ Phone: _____ DEA:_____
Reviewing RPh*_____ *Note: If anything is changed, the new Provider must authorize

Vaccine Lot#:_____ Exp Date:_____ Diluent Lot#: _____ Exp.Date:_____ Vaccine Mfg:_____ Site: **LA / RA** Date VIS Given:_____ VIS Date:_____	Vaccine Lot#:_____ Exp Date:_____ Diluent Lot#: _____ Exp.Date:_____ Vaccine Mfg:_____ Site: LA / RA Date VIS Given:_____ VIS Date:_____	Vaccine Lot#:_____ Exp Date:_____ Diluent Lot#: _____ Exp.Date:_____ Vaccine Mfg:_____ Site: LA / RA Date VIS Given:_____ VIS Date:_____

Immunizer Name/Title: _____ Date/Time Administered_____ Supervising Rph _____