

# 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?                                                                                                        |     |    |                         |
| <b>LIVE VACCINES: Zostavax, MMR, LAIV, Varicella, Yellow Fever</b>                                                                                                                                                                                                                   |     |    |                         |
| 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, its 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# \_\_\_\_\_  
**\*\*\*FOR INTERNAL USE ONLY\*\*\*** In Person of Via Cyrom (Circle One)

|                                                                                  |                                       |                                                                |
|----------------------------------------------------------------------------------|---------------------------------------|----------------------------------------------------------------|
| Vaccine: _____                                                                   | Vaccine: _____                        | Vaccine: _____                                                 |
| Sig: _____                                                                       | Sig: _____                            | Sig: _____                                                     |
| Qty: _____ Series# _____ of _____                                                | Qty: _____ Series# _____ of _____     | 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: _____                                              | Vaccine Lot#: _____ Exp Date: _____   | Vaccine Lot#: _____ Exp Date: _____                            |
| Diluent Lot#: _____ Exp. Date: _____                                             | Diluent Lot#: _____ Exp. Date: _____  | Diluent Lot#: _____ Exp. Date: _____                           |
| Vaccine Mfg: _____ Site: LA / RA                                                 | Vaccine Mfg: _____ Site: LA / RA      | Vaccine Mfg: _____ Site: LA / RA                               |
| Date VIS Given: _____ VIS Date: _____                                            | Date VIS Given: _____ VIS Date: _____ | Date VIS Given: _____ VIS Date: _____                          |
| Immunizer Name/Title: _____ Date/Time Administered: _____ Supervising Rph: _____ |                                       |                                                                |

The information transmitted in this FAX contains Confidential Patient Information, which is legally protected under HIPAA legislation and regulation. Any retransmission, dissemination or other use of this information by persons other than the intended recipient is prohibited. If this information was received in error, please immediately notify us at 859-562-2018. This vaccination consent form will permanently reside in ScriptPro, and will be stored as a paper form in 531 Wellington Way, Lexington, Ky 40503, before being move to its permanent storage location Ky Underground.