VACCINE CONSENT FORM - KANAB DRUG

PATIENT NAME_____

DATE OF BIRTH_____

PHONE_____ **MOTHER'S MAIDEN NAME***_____

STREET ADDRESS_____ **CITY**_____ **STATE**_____ **ZIP**_____

ALLERGIES**_____

BIRTH SEX: ☐M ☐F **ARE YOU PREGNANT/BREASTFEEDING?** ☐Y ☐N **HISPANIC/LATINO?** ☐Y ☐N

RACE: ☐WHITE ☐ASIAN ☐BLACK ☐PACIFIC ISLANDER ☐NATIVE AMERICAN ☐OTHER

The Utah Statewide Immunization Information System (USIIS) uses this information to identify, prevent, and resolve duplicated and fragmented patient records using an automated process.

****Please include anything that causes hives, swelling, respiratory distress, wheezing, or anaphylaxis; such as food, latex, medication, or a vaccine component.***

REQUESTED VACCINE(S): ☐**FLU** ☐**PNEUMONIA** ☐**RSV** ☐**SHINGLES** ☐**TDAP** ☐**COVID**_____

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1. Are you feeling sick today?..... ☐Y ☐N
2. Have you ever had a serious reaction after receiving a vaccination?..... ☐Y ☐N
3. Do you have any of the following? If so, please mark which……..... ☐Y ☐N
   ☐Heart disease ☐Lung disease ☐Kidney disease ☐Diabetes ☐Asthma
   ☐A blood disorder ☐No spleen ☐A cochlear implant ☐Cancer ☐Leukemia
   ☐Complement component deficiency ☐Spinal fluid leak ☐HIV/AIDS
   ☐Other immune system problems
5. Do you have a parent or sibling with an immune system problem?..... ☐Y ☐N
6. In the past 3 months, have you had/taken any of the following?..... ☐Y ☐N
   Prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?
7. Have you had a seizure or other brain/nervous system problem?..... ☐Y ☐N
8. During the past year, have you received a transfusion of blood or blood products, Or been given immune (gamma) globulin or an antiviral drug?..... ☐Y ☐N
9. Have you received any vaccinations in the past 4 weeks?..... ☐Y ☐N

Consent for Treatment & Privacy Notice

I certify that the information I have provided is true and accurate. I have had a chance to review the vaccine information (EUA Fact Sheet) and consent to receive the vaccine. I have had a chance to ask questions, which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine. I understand and agree that information related to my vaccine administration may be recorded in the Utah Statewide Immunization Information System (USIIS). I hereby release Kanab United Drug (KUD) and its employees from all claims arising from such immunizations. We are required to inform you of our privacy practices for the information we collect and keep about you. I have been given the option to receive KUD's Notice of Privacy Practices and have had an opportunity to ask questions about how my information may be used.

Signature:_____ Date:_____

Relationship to patient: ☐Self ☐Parent ☐Legal Guardian ☐Other_____

IF RECEIVING A COVID VACCINE, PLEASE SEE BACKSIDE OF FORM FOR ADDITIONAL QUESTIONS

COVID VACCINATIONS - ADDITIONAL SCREENING

1. Have you received a dose of COVID-19 vaccine?..... ☐ Y ☐ N
If yes, what vaccine product did you receive? ☐ Pfizer ☐ Moderna ☐ Janssen (J&J)
If yes, was the full vaccine series received? (1 dose J&J, 2 doses mRNA [Pfizer, Moderna])..... ☐ Y ☐ N

2. Check all that apply to you:

- ☐ Am a female between ages 18 and 49 years old
- ☐ Am a male between the ages 12 and 29 years old
- ☐ Have a history of myocarditis or pericarditis
- ☐ Had COVID-19 **AND** was treated with monoclonal antibodies or convalescent serum
- ☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after having a COVID-19 infection
- ☐ Take a blood thinner
- ☐ Have a history of heparin-induced thrombocytopenia (HIT)
- ☐ Have received dermal fillers
- ☐ Have a history of Guillain-Barre Syndrome (GBS)
- ☐ None of the above