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associated with the vaccine(s) being administered and have received, read and/or had explained to me the CDC's Vaccine Information Statement (VIS) on the vaccine(s) I have elected to	First Name:	MI:	Last Name:	VI.V.							
Primary Healthcare Provider:   Provider Address:   Provider Phone/Fax:	Home Phone:	Date of Birth:	Age:	Weight:	Gender:	er: Ethnicity:					
Insurance Carrier:    Cardholder ID:   Group Number:	Home Address:	City:			State:	Zip Code:					
TWANT TO BE PROTECTED FROM THE FOLLOWING (PLEASE CHECK ALL THAT APPLY):   FLU   HEPATITIS A   HEPATITIS B   HPV	Primary Healthcare Provider:	Provider Address:			Provider Phone/Fax:						
Please answar: the following symptoms today? Fever, cough, shortness of breath, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, diarrhea  2. In the past 14 days, have you had a fever or been exposed to or confirmed to have COVID-19, regardless of symptoms?  3. Have you had a physical examination by a healthcare provider in the last year?  4. Do you have any allergies to medications, foods (e.g. eggs), latex, or a vaccine component (e.g. gelatin, neomycin, polymykin, yeast, thimerosal, etc.)? If yes, please list what you are allergic to:  5. Have you ever had a serious reaction after receiving a vaccine? (swelling, trouble breathing, seizure, etc.)  6. Have you experienced seizures, Guillain-Barre Syndrome, or any other neurological disorder?  7. Have you experienced seizures, Guillain-Barre Syndrome, or any other neurological disorder?  8. Have you received any vaccines in the past 28 days? If yes, please list vaccine and date:  9. For Women: Are you currently pregnant, breastleeding, or are you planning to become pregnant in the next month?  10. Do you have cancer, leukemia, lymphoma, HIV/AIDS, organ transplantation, or any other immune system problem?  11. In the past 3 months, have you taken medications that weaken your immune system, such as anticancer drugs, high-dose steroids, chemotherapy, injectable therapy for rheumatoid arthritis, Crohn's disease or psoriasis (e.g. Humira, Embrel) or had radiation treatments? If yes, list medication, dose, and date last taken:  1 hereby give my consent to the health care product of the Kroger Co., its effiliates and substitutes, to admister the vaccine(s) health and when coeved or admisfor the dopshined to me the CCS. Vaccine Hormonion Statement (ViS) on the vaccine(s) three selected to received with the vaccine(s) being administered and been coeved or admisfor that depath by law or the CCS. Vaccine Mame:  1 hereby give my consent to the health care product of the Kroger Co., its effiliate	Insurance Carrier:	Cardholder ID: Group Number:				-		÷.			
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12. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? If yes, list medication, dose, and date last taken:  1 hereby give my consent to the health care provider of The Kroger Co., Its affiliates and subsidiaries, to administer the vaccine(s) I have requested above. I understand the risks and benefit associated with the vaccine(s) being administered and have received, read and/or had explained to me the CDC's Vaccine Information Statement (VIS) on the vaccine(s) I have elected to receive. I have had the opportunity to ask questions that were answered to my satisfaction. As with all medical treatment, there is no guarantee that I will not experience an adverse reactif from the vaccine. I understand that the information contained on this form may be shared with the Stated Health Division (SHD) and/or state immunization registries and will remain confidential and will not be released except as permitted or required by law. If eligible, I authorize Kroger to submit a claim for relimbursement on my behalf to Medicare or any other contracted third party payor. If the claim is denied, I understand that I will be responsible for payment. I acknowledge that I have received a copy of the Notice of Privacy Practices. Furthermore, I agree to remain near the vaccination location for approximately 15-20 minutes after administration for observation by the administering Healthcare Provider.    Date:   SIGNATURE OF PATIENT OR LEGAL GUARDIAN, IF PATIENT UNDER AGE 18]   FOR LEGAL GUARDIANS ONLY: PRINT NAME and RELATIONSHIP)    **FOR INTERNAL USE ONLY**	dose steroids, chemotherapy, injectable therapy for rheumatoid arthritis, Crohn's disease or psoriasis (e.g. Humira,										
*   globulin or an antiviral drug? If yes, list medication, dose, and date last taken:			·								
I hereby give my consent to the health care provider of The Kroger Co., its affiliates and subsidiaries, to administer the vaccine(s) I have requested above. I understand the risks and benefit associated with the vaccine(s) being administered and have received, read and/or had explained to me the CDC's Vaccine Information Statement (VIS) on the vaccine(s) I have elected to receive. I have had the opportunity to ask questions that were answered to my satisfaction. As with all medical treatment, there is no guarantee that I will not experience an adverse reactif from the vaccine. I understand that the information contained on this form may be shared with the Stated Health Division (SHD) and/or state immunization registries and will remain confidential and will not be released except as permitted or required by law. If eligible, I authorize Kroger to submit a claim for reimbursement on my behalf to Medicare or any other contracted third party payor. If the claim is denied, I understand that I will be responsible for payment. I acknowledge that I have received a copy of the Notice of Privacy Practices. Furthermore, I agree to remain near the vaccination location for approximately 15-20 minutes after administration for observation by the administering Healthcare Provider.    Date:	2 12. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma)										
associated with the vaccine(s) being administered and have received, read and/or had explained to me the CDC's Vaccine Information Statement (VIS) on the vaccine(s) I have elected to receive. I have had the opportunity to ask questions that were answered to my satisfaction. As with all medical treatment, there is no guarantee that I will not experience an adverse reactifrom the vaccine. I understand that the information contained on this form may be shared with the Stated Health Division (SHD) and/or state immunization registries and will remain confidential and will not be released except as permitted or required by law. If eligible, I authorize Kroger to submit a claim for reimbursement on my behalf to Medicare or any other contracted third party payor. If the claim is denied, I understand that I will be responsible for payment. I acknowledge that I have received a copy of the Notice of Privacy Practices. Furthermore, I agree to remain near the vaccination location for approximately 15-20 minutes after administration for observation by the administering Healthcare Provider.    Date:							<u> </u>	1 "			
* FOR INTERNAL USE ONLY * REQUIRED: obtained verbal consent to treat prior to administration  Vaccine Name: Vaccine Name: Vaccine Name: Manufacturer: Manufacturer: Manufacturer:	associated with the vaccine(s) being administered and have received, read and/or had explained to me the CDC's Vaccine Information Statement (VIS) on the vaccine(s) I have elected to receive. I have had the opportunity to ask questions that were answered to my satisfaction. As with all medical treatment, there is no guarantee that I will not experience an adverse reaction from the vaccine. I understand that the information contained on this form may be shared with the Stated Health Division (SHD) and/or state immunization registries and will remain confidential and will not be released except as permitted or required by law. If eligible, I authorize Kroger to submit a claim for reimbursement on my behalf to Medicare or any other contracted third party payor. If the claim is denied, I understand that I will be responsible for payment. I acknowledge that I have received a copy of the Notice of Privacy Practices.  Furthermore, I agree to remain near the vaccination location for approximately 15-20 minutes after administration for observation by the administering Healthcare Provider.  Date:  Date:										
Vaccine Name:	(SIGNATURE OF PATIENT OR LEGAL GUARDIAN	I, IF PATIENT UNDER AGE 18) (FC	OR LEGAL GUARD	IANS ONLY: PRIN	IT NAME and RELATIO	NSHIP)					
Manufacturer: Manufacturer: Manufacturer: Manufacturer:			erbal consen								
Dose: Series #: or   Dose: Series #: ol   Dose: Series #: or   Dose: Series #: or   Dose:   Series #:   Or   Dose:   Series #:   Or   Dose:   Series #:   Or   Dose:   Series #:   Or   Dose:   Series #:   Or   Dose:   Series #:   Or   Dose:   Series #:   Or   Dose:   Series #:   Or   Dose:   Series #:   Or   Dose:   Series #:   Or   Dose:   Series #:   Or   Dose:   Series #:   Or   Dose:   Series #:   Or   Dose:   Series #:   Or   Dose:   Series #:   Or   Dose:   Series #:   Or   Dose:   Series #:   Or   Dose:   Series #:   Or   Dose:   Dose:   Series #:   Dose:   Series #:   Dose:   Series #:   Or   Dose:											
			e Lot #: Series #: of Vaccine Lot #:		#:	OI					
l		accine Exp. Date: Vaccine Exp. Date:			-	<del></del>					
Vaccine Exp. Date:       Vaccine Exp. Date:       Vaccine Exp. Date:       Vaccine Exp. Date:         Diluent Lot #/Exp. Date:       Diluent Lot #/Exp. Date:       Diluent Lot #/Exp. Date:	<b>!</b>	Diluent Lot #/Exp. Date:		Diluent Lot #/Fxp. Date:							
Injection Site: LEFT/RIGHT; ARM/THIGH Injection Site: LEFT/RIGHT; ARM/THIGH Injection Site: LEFT/RIGHT; ARM/THIGH								<u></u> -			
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☐ REQUIRED: counseled patient to remain near location for 15 to 20 mlns Supervising RPh/Lic#:(If required)											
Immunizer: Date Administered://Time:AM/PM											
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