Clinic Vaccination

Assessment, Release, & Consent Form

12741 Q Street Omaha, NE 68137
402-973-1933
vaccineclinic@kohlls.com

Company Name: _____ Date: _____

Name: _____ DOB: _____ - _____ - _____ Age: _____ Sex: M / F (Circle One)

Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ - _____ - _____

If you are listed as a dependent of an employee, please write the employee's name: _____

PLEASE CIRCLE THE ANSWERS TO THE FOLLOWING QUESTIONS:

1. Are you sick today? YES NO
2. Do you have allergies to medications, food, a vaccine component, or latex? YES NO
3. Have you ever had a serious reaction after receiving a vaccine? YES NO
4. Do you have a long-term health problem with heart, lung, kidney, or metabolic disease (e.g. diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? YES NO
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem? YES NO
6. In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatment? YES NO
7. Have you had a seizure or a brain or other nervous system problem? YES NO
8. During the past year, have you received a transfusion of blood or blood products, or been given immune globulin or an antiviral drug? YES NO
9. Have you ever had Guillain-Barre syndrome? YES NO
10. **Females:** Are you currently pregnant, lactating, or could become pregnant in the next month? YES NO
11. **Females:** Have you had a mastectomy? YES NO

I have read the above information or have had the information explained to me. I have had a chance to ask questions and these have been answered to my satisfaction. I understand the benefits and the risks and ask that the vaccine(s) is/are given to me, or to the person named above for whom I am authorized to make this request. I accept responsibility for seeking medical attention for any problems with this vaccination. I agree to stay in the vaccine administration area for 15 minutes or longer if indicated by the vaccine administrator after receiving my vaccine to ensure that no immediate adverse reactions occur. If the company named above has not authorized direct billing, I authorize billing of the vaccine(s), their administration, and counseling/education to my health insurance plan and will provide that information as requested. If for any reason my insurance does NOT pay for these services either in part or in full, I agree to pay the full amount.

Patient or Guardian Signature: _____ **Date**:_____

Date Given	**Type**	**Name** (Please circle.)	**Dose (mL)**	**Lot #**	**Location**	**Initials**
	Inactivated influenza	Fluarix / Afluria / Flulaval	0.5 mL		R L	
	Inactivated influenza (egg free)	Flucelvax	0.5 mL		R L	
	Inactivated influenza (65+)	Fluad Quad	0.5 mL		R L	
	COVID-19	Moderna / Pfizer / Novavax			R L	
	RSV (60+)	Abrysvo	0.5 mL		R L	
	Pneumococcal	Prevnar 20 / Pneumovax 23	0.5 mL		R L	