



# Influenza Vaccination

Pharmacy & Homecare

To be completed by store personnel:

Insurance Card Copied?: \_\_\_ Paid Cash: \_\_\_ Store Location: \_\_\_  
Shot Location **L** or **R** Deltoid Initials \_\_\_\_\_ V.I.S. 8/10 /10

## Assessment, Release & Consent Form

Date \_\_\_ - \_\_\_ - \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_ - \_\_\_ - \_\_\_ Sex: Male Female (Circle One)  
Print name EXACTLY as it appears on Insurance Card month date year

Phone (402) \_\_\_ - \_\_\_ Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_

What is your **PRIMARY INSURANCE**? \_\_\_\_\_ Complete the needed information.

1. Policy #: \_\_\_\_\_ Group # (if applicable) \_\_\_\_\_

2. Is this a Medicare HMO/Advantage Plan? \_\_\_\_\_

3. Do you have both Medicare Part A (hospital) and Medicare Part B (medical)? Yes No

4. Please have **all of your insurance cards** out and ready for a Kohl's employee to copy & attach to this form.

5. Please **Pay** at register if Medicare OR BCBS **is not** your primary insurance.

### PLEASE CIRCLE THE ANSWERS TO THE FOLLOWING QUESTIONS:

1. Have you ever had a severe reaction to any vaccine? YES NO

2. Do you have any severe drug or food allergies? YES NO

If yes, are you allergic to EGGS, CHICKEN, OR CHICKEN FEATHERS? YES NO

If yes, are you allergic to THIMEROSAL, NEOMYCIN OR GELATIN? YES NO

If yes, are you allergic to POLYMYXIN B, KANAMYCIN OR GENTAMICIN? YES NO

If yes, are you allergic to POLYSORBATE 80 OR HYDROCORTISONE? YES NO

3. How are you today? Do you have any substantial fever, diarrhea, or vomiting? YES NO

4. Have you received the pneumonia vaccine in the last 5 years? YES NO

If yes, how old were you when you received the vaccine? \_\_\_\_\_

5. Women: Have you had a mastectomy? YES NO

6. Women: Are you pregnant? YES NO

### **Please answer the following question for children less than 9 years old**

7. Did your child receive the recommended two-dose series of the H1N1 Influenza vaccination last year? 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 of the influenza vaccine and ask that the vaccine is 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 authorize billing of this vaccination to my health insurance. If for any reason my insurance does not pay for the vaccination, I agree to pay the full amount of the procedure.

Signature \_\_\_\_\_ Date \_\_\_ / \_\_\_ / \_\_\_\_\_

|  |     |    |            |
|--|-----|----|------------|
| Have you received a Tetanus shot in the last 10 years? | Yes | No | Don't Know |
| If you are over 60: Have you had a shingles shot?      | Yes | No | Don't Know |