Worried about new immunization guidelines? We're here to help!

Effective July 1, 2018

- All students in (K-12) kindergarten through twelfth grade must show proof of having received two doses of Hepatitis A vaccine to attend school.
- All students 16-years-old and older must receive a meningitis booster to attend school.

(902 KAR 2:060)

☐ **For students with commercial insurance or cash-pay:**
Sign-up for in school clinic by contacting school nurse.

OR

Visit Eastridge-Phelps Pharmacy
500 N Bypass, Campbellsville, KY 42718
(Monday through Thursday from 9:00AM to 6:00PM)

* **Consent forms must be completed before vaccination and can be obtained at www.eastridgephelps.com or from the school nurse. Please return completed forms to the school nurse or by faxing to (270) 789-0578.**

☐ **For students insured by KY Medicaid (ie. Wellcare, Passport, Anthem Medicaid, Aetna Better Health, Humana CareSource) or students without insurance:**

Contact: Taylor County Health Department
1880 N Bypass, Campbellsville, KY 42718
(270) 465-4191

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Vaccine Consent and Assessment

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First Name:	MI:	Last Name:		
Home Phone: ( )	Date of Birth: / /	Age:	Weight:	Gender:
Home Address:		City:	State:	Zip:
Primary Care Provider:				

I WANT TO BE PROTECTED FROM THE FOLLOWING (PLEASE CHECK ALL THAT APPLY):

☐ Flu ☐ Hepatitis A ☐ Hepatitis B ☐ HPV ☐ Measles/Mumps/Rubella (MMR) ☐ Meningitis ☐ Pneumonia
☐ Shingles ☐ Tetanus, Diphtheria, +/- Pertussis ☐ Varicella ☐ Other: _____

	Yes	No	Don't Know
1. Are you sick today?	☐	☐	☐
2. Do you have allergies to medications, food, a vaccine component, or latex?	☐	☐	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☐	☐
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g. diabetes), anemia, or other blood disorder?	☐	☐	☐
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
6. In the past 3 months, have you taken medications that affect you 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 treatments?	☐	☐	☐
7. Have you had a seizure or a brain or other nervous system problem?	☐	☐	☐
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?	☐	☐	☐
9. For Women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
10. Have you received any vaccinations in the past 4 weeks?	☐	☐	☐

I hereby give my consent to the pharmacist of Eastridge-Phelps Pharmacy, to administer the vaccine(s) I have requested. I understand the risks and benefits 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 or medication. I fully release and hold harmless Eastridge-Phelps Pharmacy, its pharmacists and employees from any and all liabilities or claims arising out of, in connection with, or in any way related to the administration of the vaccine(s) given. 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 Eastridge-Phelps Pharmacy to submit a claim for reimbursement on my behalf to Medicare or any other contracted third-party payer. If the claim is denied, I understand that I will be responsible for payment. I acknowledge that I have received a copy of the Eastridge-Phelps Pharmacy 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 pharmacist.**

✗ _____ Date: _____
(Signature of Patient or Parent/Guardian)

(For Pharmacy Use Only) The following section is to be completed by the pharmacy.

Vaccine Name: _____ Manufacturer: _____ Dose: _____ Vaccine Lot#: _____ Vaccine Exp: _____ Diluent Lot/Exp: _____	Vaccine Name: _____ Manufacturer: _____ Dose: _____ Vaccine Lot#: _____ Vaccine Exp: _____ Diluent Lot/Exp: _____	Vaccine Name: _____ Manufacturer: _____ Dose: _____ Vaccine Lot#: _____ Vaccine Exp: _____ Diluent Lot/Exp: _____
Injection Site: **LEFT ARM** **RIGHT ARM** **Route:** **IM** **SubQ** Immunizer: _____ Date Given/VIS Given: _____/_____/_____ VIS Version Date: _____/_____/_____	**Injection Site:** **LEFT ARM** **RIGHT ARM** **Route:** **IM** **SubQ** Immunizer: _____ Date Given/VIS Given: _____/_____/_____ VIS Version Date: _____/_____/_____	**Injection Site:** **LEFT ARM** **RIGHT ARM** **Route:** **IM** **SubQ** Immunizer: _____ Date Given/VIS Given: _____/_____/_____ VIS Version Date: _____/_____/_____