

Kusler's Compounding Pharmacy
700 Avenue D, Ste 102
Snohomish, WA 98290

Vaccination Consent Form

Information about person to receive vaccine(s) (Please print):

Name: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____

Allergies: _____

Egg allergy? Yes / No Guillain Barre Syndrome? Yes / No

Chronic Conditions: _____

Primary Care Physician: _____

"I have read or have had explained to me the information in the CDC Vaccine Information Statement(s). I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of this/these vaccine(s) and ask that the vaccine(s) be given to me

Signature

Date

For Pharmacy Use

#1

#2

#3

Date / Time Administered			
Vaccine			
Manufacturer			
Lot Number			
Expiration Date			
Site and Route of Injection			
Date of VIS	08/15/2019		
Signature of Administrator			

Continue on back →

Covid-19 Symptom Screening

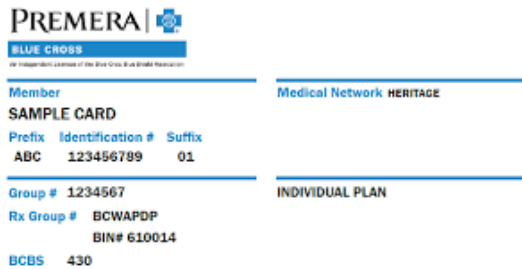
Do you have any of these symptoms?


Cough	Y	N
Fever in the last 7 days	Y	N
Shortness of breath	Y	N
Sore throat	Y	N
Diarrhea	Y	N
Loss of appetite	Y	N
Loss of smell	Y	N
Body Chills	Y	N
Muscle pain	Y	N

Have you been in contact with a Covid-19 positive patient? Y N

Travel outside the State of Washington? Y N

Temperature Check _____



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BLUE CROSS
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Member Medical Network HERITAGE

SAMPLE CARD

Prefix Identification # Suffix
ABC 123456789 01

Group # 1234567 INDIVIDUAL PLAN
 Rx Group # BCWAPDP
 BIN# 610014

BCBS 430

ID Number _____



 **Uniform MedSource Star**

SUBSCRIBER SAMPLE

ID NO UDW W72345678

00 SUBSCRIBER SAMPLE

 **Regence**

Group No. 10003948
 Group Name PEBB

M	D	RX	V
Y	N	Y	Y

MedImpact®
 RX BIN: 003585 RX PCN: 38600
 RX Group: 10008217



ID Number _____



KAISER PERMANENTE Kaiser Foundation Health Plan of Washington Core

RxBIN 610011
 RxCN IRX
 RxGrp GCOHBE

ID: **06000002**

Name: **JOHN SAMPLE**



ID Number _____