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?

Symptom		
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 ___________

PREMERA | BLUE CROSS

Member
SAMPLE CARD
Prefix Identification # Suffix
ABC 123456789 01

Medical Network HERITAGE

Group # 1234567
Rx Group # BCWAPDP
BIN# 610014
BCBS 430

INDIVIDUAL PLAN

ID Number____________________

Uniform Medical Plan
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

PPO

ID Number____________________

KAISER PERMANENTE. Kaiser Foundation Health Plan of Washington
RxBIN 610011
RxPCN IRX
RxGrp GCOHBE
Core
ID:
06000002
Name:
JOHN SAMPLE
First Health

ID Number____________________