Vaccine Administration Record (VAR) Informed Consent for Vaccination

Community Pharmacy

PATIENT: COMPLETE SECTIONS A, B, C

SECTION A *(Please print clearly.)* ***I want to receive the following immunization(s):*** ☐ *Flu (influenza)* ☐ *Pneumonia (pneumococcal)*

First name: _____ **Last name:** _____ **Date of birth:** _____ **Age:** _____

Gender: ☐ Male ☐ Female **Race:** ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ American Indian ☐ Pacific Islander ☐ Other

Home address: _____ **City:** _____ **State:** _____ **ZIP code:** _____

Home phone: _____ **Mobile phone:** _____

Email address: _____ **Mother's Maiden Name:** _____

Doctor/primary care provider name: _____ **Phone number:** _____

SECTION B

1)	Do you feel sick today?	☐ Yes ☐ No ☐ I Don't Know
2)	Have you ever had a reaction after receiving an immunization, including fainting or feeling dizzy?	☐ Yes ☐ No ☐ I Don't Know
3)	Do you have any health conditions such as: heart disease, diabetes, or asthma? a. If yes, please list	☐ Yes ☐ No ☐ I Don't Know
4)	Do you have an immunocompromising condition (e.g. Cancer, leukemia, lymphoma, HIV/AIDS, transplant), functional, or anatomic asplenia, CSF leak or cochlear implant?	☐ Yes ☐ No ☐ I Don't Know
5)	Do you have allergies to latex, medications, food or vaccines? (Examples: eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal) a. If yes, please list	☐ Yes ☐ No ☐ I Don't Know
6)	Have you ever had a seizure disorder for which you are on seizure medications, a brain disorder, Guillain-Barre syndrome or other nervous system problems?	☐ Yes ☐ No ☐ I Don't Know
7)	**For Women:** Are you pregnant or considering becoming pregnant in the next month?	☐ Yes ☐ No ☐ I Don't Know

SECTION C

I authorize the release of any medical or other information with respect to this vaccine to my healthcare providers, Medicare, Medicaid or other third party payer as needed and request payment of authorized benefits to be made on my behalf to Community Pharmacy.

- I acknowledge that if my insurance does not cover the cost of administering the vaccine at the pharmacy, then payment must be made at the time of the administration of the vaccine.
- I acknowledge that my vaccination record may be shared with federal or state or city agencies for registry reporting.
- I acknowledge that the pharmacist recommends that vaccinated patients should remain in the waiting area, for 20 minutes, after the administration of the immunization.
- I acknowledge receipt of Community Pharmacy's Notice of Privacy Practices for Protected Health Information.
- I acknowledge that the administration of an immunization or vaccine does not substitute for an annual check-up with the patient's primary care physician.
- I have read, or have had read to me the Vaccination Information Sheet (VIS) regarding the vaccine(s). I have had the opportunity to ask questions that were answered to my satisfaction and understand the benefits and risks of the vaccine(s). I consent to, or give consent for, the administration of the vaccine(s). I fully release and discharge Community Pharmacy LLC, its affiliates, officers, directors, and employees from any liability for illness, injury, loss, or damage which may result there from.

Signature: _____ **Date:** _____
(Parent or guardian, if minor)

Pharmacy Use Only Below Line

Complete AT vaccine administration

Vaccine	NDC	Dosage	Admin Site	VIS Date	Lot #	Expiration Date
Flulaval Quad PFS Flucelavax Quad PFS	[ ]19515-0808-52 [ ]70461-0322-03	0.5mL	L / R IM / SQ	8/06/2021	[ ] 2G7K9 [ ] 942381	[ ] 06/12/2023 [ ] 06/08/2023
Fluzone Quad HD PFS FluAd Quad HD PFS	[ ] 49281-0122-65 [ ] 70461-0122-03	[]0.7mL []0.5mL	L / R IM / SQ	8/06/2021	[ ] [ ] 346346	[ ] [ ] 04/21/2023
Prevnar 20 Pneumovax 23	[ ]00005-2000-10 [ ]00006-4837-03	0.5mL	L / R IM	2/04/2022	[ ] [ ]	[ ] [ ]

Immunizer name (print): _____ **Immunizer signature:** _____ **Title: RPh/PharmD**

Administration Date and Date VIS Given to Patient: _____

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