Vaccine Administration Record (VAR) - Informed Consent for Vaccination

Acton Pharmacy Keyes Drug Theatre Pharmacy West Concord Pharmacy

Section A: Patient Information

Last Name: _____ First Name: _____M.I.: ____

Date of Birth: _____ Age: _____ [ ]Male [ ]Female Phone: _____

Street Address: _____

City: _____ State: _____ Zip: _____ Email: _____

Primary Care Physician Name: _____ Physician Phone: _____

Section B: Medical Information

The following questions will help us determine your eligibility to be vaccinated today:

1. Do you feel sick today? [ ]Yes [ ]No

2. Have you been vaccinated in the past 28 days? [ ]Yes [ ]No
If so, please list: _____

3. Do you have any health conditions such as: Heart Disease, Diabetes, Cancer or Asthma?If yes, please list (if Cancer, currently on Chemo?) _____ [ ]Yes [ ]No [ ]I don't know

4. Do you have allergies to <u>latex</u>, medications, food or vaccines? [ ]Yes [ ]No [ ]I don't know
(Examples: <u>Eggs</u>, Cow protein, Gelatin, Gentamicin, Polymyxin, Neomycin, Phenol, Yeast, or Thimerosal) If yes, please list _____

5. Have you ever had a reaction after receiving an immunization, including fainting or feeling dizzy? [ ]Yes [ ]No

6. Have you ever had a seizure disorder for which you are taking seizure medication(s), a brain disorder, Guillain-Barre' Syndrome (a condition that causes paralysis) or other nervous system disorder? [ ]Yes [ ]No

7. <u>For women</u>: Are you pregnant or considering becoming pregnant in the next month? [ ]Yes [ ]No [ ]I don't know

8. Are you on/have you taken recently any corticosteroids such as Prednisone? If yes, when was your last dose and what was your dose:_____ [ ]Yes [ ]No

Section C

I have read or had read to me, the Vaccine Information Statement(s) (VIS) indicated below. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) and understand the possible side effects include, but are not limited to, pain or redness at injection site, headache, fever, muscle or nerve pain, Guillain-Barre Syndrome, allergic reactions, and encephalitis. I understand it is not possible to predict all possible side effects or complications associated with the vaccine(s). I consent to, or give consent for my child, the administration of the vaccine(s) below. I authorize the information to be forwarded to my primary care physician, authorizing physician and vaccine registry. I agree to stay in the general area for 15 minutes after receiving my vaccination(s) in case any immediate reactions occur. I understand that if I experience any side effect(s), it will be my responsibility to follow up with my physician at my expense. I hereby release Dinno Health Pharmacies and its employees from any and all liability that might arise from this vaccination(s) on behalf of me, my heirs, and personal representatives.

_____ _____ _____

Patient/Parent/Guardian Signature | Printed Patient/Parent/Guardian Name | Date

Section D *(To be completed by PHARMACY)*

Vaccines: [ ]Flu [ ]Pneumonia [ ]TDaP [ ]Shingrix [ ]Other

Vaccine	NDC	Dosage	Site of Administration	VIS Published Date	Lot	Expiration
	:	:	:	:	:	:

Immunizer Name (print):_____ Immunizer Signature: _____

Administration Date:_____ Date VIS given to patient: _____

<u>Prescription</u> Insurance Provider: _____ Medicare number *(if applicable)*: _____

ID _____ RX GRP _____ BIN _____ PCN _____