Vaccine Administration Record (VAR) – Informed Consent for Vaccination

PHARMACY □ 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: *To be completed by PATIENT* *Vaccine(s): [ ] **Flu** [ ] **Pneumonia** [ ] **TdaP** [ ] **Shingrix** [ ] **Other***

Section C: Medical Information

The following questions will help us determine your eligibility to be vaccinated today (please ask for assistance if needed):

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

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

3. Do you have any health conditions, such as: Heart Disease, Diabetes, Cancer, or Asthma? **[ ] Yes [ ] No**
If yes, please list (if Cancer, currently on Chemo?):_____
_____

4. Do you have ALLERGIES to medications, <u>latex</u>, food, or vaccines? **[ ] Yes [ ] No**
Examples: Egg protein, Cow protein, Gelatin, Gentamicin, Polymixin, Neomycin, Phenol, Yeast, or Thiomersol. If yes, please list:_____

5. Have you ever had a serious reaction after receiving an immunization, including fainting or feeling dizzy?
Did you require medical assistance? **[ ] 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, considering to become pregnant in the next month, or breastfeeding? **[ ] Yes [ ] No**

8. Are you on, or have you recently taken medications that affect your immune system?
Examples: corticosteroids (Prednisone), anti-rejection medications, chemotherapy **[ ] Yes [ ] No**
If yes, when was your last dose and what was the dose taken?_____

Section D: Consent Statement

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 the 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 dependent, the administration of the vaccine(s) below. I authorize the information to be forwarded to my primary care physician, authorizing physician, and any applicable vaccine registry. I agree to stay in the general area for 15 minutes after receiving my vaccine(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 E: *To be completed by Pharmacy*

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

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

Immunizer Name (print):_____ Immunizer Signature:_____

Administration Date: _____ Date VIS given to patient: _____

Version 91521