

Vaccine Administration Record (VAR) – Informed Consent for COVID-19 Vaccination

Acton Pharmacy Keyes Drug Theatre Pharmacy West Concord Pharmacy



Section A: Patient Information

Start Here:

Last Name	First Name	Date of Birth	Gender
Address	City	State	Zip
Home Telephone	Mobile	E-mail	
Primary Care Provider name	PCP Phone Number	PCP Fax Number	
PCP Address	City	State	Zip
<input type="checkbox"/> First Dose <input type="checkbox"/> Second Dose <input type="checkbox"/> 3rd Dose <input type="checkbox"/> Booster <input type="checkbox"/> 2nd Booster			
Is this the patient's		Race	Ethnicity

Section B: Insurance Information *(No need to fill out if BRINGING A COPY of your insurance cards)*

Prescription Insurance:	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Are you the primary cardholder		If no, relationship to cardholder	
Prescription Benefit plan name	Cardholder/Member ID#	Rx Group ID#	RxBIN	RxPCN
Medicare Fields: <input type="checkbox"/> Yes <input type="checkbox"/> No				
Do you have Medicare A&B		Medicare number (refer to your Medicare Red, White, and Blue card)		

If uninsured, you must check the box below to attest that the following information is true and accurate:

- I do not have any insurance, including but not limited to Medicare, Medicaid or any other private or government-funded health benefit plan. In order to have your vaccine administration fee paid for by the United States Health Resources & Services Administration's COVID-19 Program for Uninsured Patients, please provide either (a) a valid Social Security number, (b) state identification number and state of issuance, or (c) a driver's license number and the state of issuance.

Social Security Number	State Identification Number & State	Driver's License Number & State
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Section C: Medical Information

	YES	NO	DON'T KNOW
1. Are you feeling sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever received a dose of COVID-19 vaccine? How many? ____ When was last dose? ____ If yes, please indicate <input type="checkbox"/> Moderna <input type="checkbox"/> Pfizer <input type="checkbox"/> Janssen (J&J) <input type="checkbox"/> Another product:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had a severe allergic reaction (e.g., anaphylaxis, fainting or dizziness) in the past to ANYTHING? For example, a reaction for which you were treated with epinephrine, or for which you had to go to the hospital?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was the severe allergic reaction after receiving a COVID-19 vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was the severe allergic reaction after receiving another vaccine or medication?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was the severe allergic reaction related to receiving Polyethylene Glycol or Polysorbate or products containing Polyethylene Glycol, OR Polysorbate ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Have been diagnosed w/ multisystem inflammatory syndrome (MIS-C or MIS-A) after a COVID-19 infection?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have a history of Myocarditis or Pericarditis ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you received monoclonal antibodies or convalescent plasma as part of a COVID-19 treatment in the past 90 days?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have a bleeding disorder or are you taking a blood thinner? Do you have history or at risk for clots ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever had a seizure disorder for which you are taking seizure medication(s), a brain disorder, Guillain-Barre' Syndrome or other nervous system disorder ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.* Are you moderately/severely immunocompromised (ie: HIV, cancer treatment), a transplant patient, or taking immunosuppressing medication (ex: anti-rejection medications, medications for RA, high-dose steroids)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. For women: Are you currently pregnant or breast feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you received dermal fillers? If yes, where on your body? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Section D: Consent

CONSENT FOR SERVICES: I have been provided with the Vaccine Information Sheet(s) or patient fact sheet corresponding to the vaccine(s) or EUA for COVID-19 vaccine that I am receiving. I have read the information provided about the vaccine I am to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I have voluntarily assumed full responsibility for any reactions that may result. I understand that I should remain in the vaccine administration area for a minimum of 15 minutes after the vaccination to be monitored for any potential adverse reactions. I understand if I experience side effects that I should do the following: call the pharmacy, contact my doctor and/or call 911. I request that the vaccine be given to me or to the person named above for whom I am authorized to make this request.

AUTHORIZATION TO REQUEST PAYMENT: I do hereby authorize The Pharmacy to release information and request payment.

I certify that the information given by me in applying for payment under Medicare or Medicaid, Private Insurance or the HRSA COVID-19 program for Uninsured Patients, is correct. I authorize benefits be made on my behalf.

DISCLOSURE OF RECORDS: I understand that The Pharmacy may be required to or may voluntarily disclose my health information to the physician responsible for this protocol of specific health information of people vaccinated at The Pharmacy or at Clinics (if applicable), and/or my Primary Care Physician (if I have one), and/or my insurance plan, and/or health systems and hospitals, and/or state or federal registries such as Massachusetts Vaccine Registry (MIIS), for purposes of treatment, payment, or other health care operations (such as administration or quality assurance). I also understand that The Pharmacy will use and disclose my health information as set forth in the Notice of Privacy Practices (copy is available in-store, on-line or by requesting a paper copy from the pharmacy).

AUTHORIZATION: I do hereby consent the Pharmacy to submit vaccination data to state and federal vaccination registries.

X

Signature of patient to receive vaccine (or parent, guardian, or authorized representative) **Date**
If signing on behalf of the patient, you are stating that you are authorized to provide the required consent on behalf of the patient.

Name of parent, guardian, or authorized representative	Phone number	Relationship
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Section E: Vaccine Administration Information *(for Pharmacy use only)* **COVID-19 VACCINE**

Moderna Pfizer 0.25 0.3
 Janssen J&J Another product: 0.5 other

Administration Date	Time In	Time Out	VIS Date	Manufacturer	Volume (ml)
				IM <input type="checkbox"/> L <input type="checkbox"/> R Deltoid	
Lot #		Exp. Date	Route	Site	Patient Temperature (°F)

Administering Immunizer Name & Title



Administering Immunizer Signature

