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

☐ Acton Pharmacy ☐ Keyes Drug ☐ Theatre Pharmacy ☐ West Concord Pharmacy

DINNO HEALTH

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

☐ **First Dose** (primary series) ☐ **Second Dose** (primary series) ***or*** ☐ **Booster** (Bivalent)

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: ☐ Yes ☐ No | ☐ Yes ☐ 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:

☐ Yes ☐ 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

Section C: Medical Information	YES	NO	DON'T KNOW
1. Are you feeling sick today?	☐	☐	☐
2. Have you ever received a dose of COVID-19 vaccine? How many? _____ When was last dose? _____	☐	☐	☐
If yes, please indicate ☐ Moderna ☐ Pfizer ☐ Janssen (J&J) ☐ Another product:			
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?	☐	☐	☐
Was the severe allergic reaction after receiving a COVID-19 vaccine?	☐	☐	☐
Was the severe allergic reaction after receiving another vaccine or medication?	☐	☐	☐
Was the severe allergic reaction related to receiving **Polyethylene Glycol or Polysorbate** or products containing **Polyethylene Glycol, OR Polysorbate**?	☐	☐	☐
4. Have been diagnosed w/ multisystem inflammatory syndrome (MIS-C or MIS-A) after a COVID-19 infection?	☐	☐	☐
5. Do you have a history of **Myocarditis or Pericarditis?**	☐	☐	☐
6. Have you received monoclonal antibodies or convalescent plasma as part of a COVID-19 treatment in the past 90 days?	☐	☐	☐
7. Do you have a **bleeding disorder** or are you taking a blood thinner? Do you have history or **at risk for clots**?	☐	☐	☐
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?**	☐	☐	☐
9.* Are you moderately/severely immunocompromised (ie: HIV, cancer treatment), a transplant patient, or taking immunosupressing medication (ex: anti-rejection medications, medications for RA, high-dose steroids)?	☐	☐	☐
10. **For women**: Are you currently pregnant or breast feeding	☐	☐	☐
11. Have you received dermal fillers? If yes, where on your body? _____	☐	☐	☐

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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 herby 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**

Section E: Vaccine Administration Information (*for Pharmacy use only*) COVID-19 VACCINE

☐ Moderna ☐ Pfizer ☐ 0.25 ☐ 0.3

N/A ☐ Janssen J&J ☐ Another product: ☐ 0.5 ☐ other

Administration Date	Time In	Time Out	VIS Date	Manufacturer	Volume (ml)
				IM ☐ L ☐ R Deltoid	

Lot #	Exp. Date	Route	Site	Patient Temperature (°F)

Administering Immunizer Name & Title **Administering Immunizer Signature**

Moderna COVID-19 Vaccine Information Sheet Pfizer-BioNTech COVID-19 Vaccine Information Sheet Janssen COVID-19 Vaccine Information Sheet