



DINNO
HEALTH
PHARMACY

Acton Pharmacy

Keyes Drug

Theatre Pharmacy

West Concord Pharmacy

Vaccine Administration Record (VAR) – Informed Consent for Vaccination



DINNO
HEALTH

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 conditions, such as: Heart Disease, Diabetes, Cancer, Bleeding Disorder, or Asthma? [] Yes [] No
If yes, please list (if Cancer, currently on Chemo? Anti-Coagulation Meds?): _____
- 4. Do you have ALLERGIES to medications, latex, 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? [] Yes [] No
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. For women: 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? [] Yes [] No
Examples: corticosteroids (Prednisone), anti-rejection medications, chemotherapy
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

Table with 7 columns: Vaccine, NDC, Dosage, Site of Administration, VIS Published Date, Lot#, Expiration Date

Table with 7 columns: Vaccine, NDC, Dosage, Site of Administration, VIS Published Date, Lot#, Expiration Date

Immunizer Name (print): _____ Immunizer Signature: _____

Administration Date: _____ Date VIS given to patient: _____