Vaccine Administration Record (VAR) – Informed Consent for Vaccination

Walgreens

I.E	the notions is requesting a flu vessionities. Indicate the notionals	1				
	the patient is requesting a flu vaccination, indicate the patient's age group:	OFF-SITE CLINIC BILLING GROUP:	Store number:			
1	l Under age 65 I Age 65 or older		Rx number: Store address:			
			Otoro addroso:			
	ECTION A Please print clearly.	Last name:				
Da	ite of birth: Age:	Gender: Female Male Male Male Male Male Male Male Male Male Male Male Male Male Male Male Male Male Male Male Male Male Male Male Male Male Male Male Male	Phone			
	I wish to receive text message alerts regarding my presc					
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	ome address: ZIP code: Email add		City:			
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Etl	hnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unk	nown ethnicity				
	algreens will send vaccination information from this visit t	,	vider using the contact	informat	ion pro	ovided below.
	octor/primary care provider name:				ion pro	ovided below
	Idress:				D code	
Au	uness:	City:	State:	21	P Coue	
IV	vant to receive the following vaccination(s):					
S	ECTION B The following questions will help us determine your	eligibility to be vaccinated today.				
All	vaccines					
1.	Do you feel sick today?					☐ Don't know
	Have you been diagnosed with or tested positive for COVID-19 in t	•				□ Don't know
	In the past 14 days have you been identified as a close contact to					□ Don't know
4.	Do you have a history of allergic reaction or allergies to latex, med polysorbate, eggs, bovine protein, gelatin, gentamicin, polymyxin, If yes, please list:			□ Yes	□ No	□ Don't know
5.	Have you ever had a reaction after receiving a vaccination, includir	ng fainting or feeling dizzy?		☐ Yes	□ No	☐ Don't know
6.	Have you ever had a seizure disorder for which you are on seizure (a condition that causes paralysis) or other nervous system probler		in-Barré syndrome	□ Yes	□No	☐ Don't know
7.	Have you received any vaccinations or skin tests in the past eight v If yes, please list:	veeks?		□ Yes	□No	☐ Don't know
	Have you ever received the following vaccinations? □ Pneumonia: Date received □ Shingles:					
9.	Do you have any chronic health conditions such as cancer, chronic obesity, sickle cell disease, diabetes, asthma or heart disease? If yes, please list:	kidney disease, immunocompromised	l, chronic lung disease,	□ Yes	□ No	□ Don't know
10.	. For women: Are you pregnant or considering becoming pregnant ir	the next month?		☐ Yes	□ No	☐ Don't know
11.	For COVID-19 vaccine only: Have you been treated with antibo or convalescent plasma)?	dy therapy specifically for COVID-19	(monoclonal antibodies	□ Yes	□No	□ Don't know
	For chickenpox, MMR® II, shingles, Vaxchora®, yellow feve Answer the following questions only if you are receiving ar			·		
12.	. Do you have a condition that may weaken your immune system (e		/AIDS, transplant)?	☐ Yes	□No	☐ Don't know
13.	. Are you currently on home infusions, weekly injections such as Hur (etanercept), high-dose methotrexate, azathioprine or 6-mercaptor			□ Yes	□No	□ Don't know
14.	Are you currently taking high-dose steroid therapy (prednisone > 2	20mg/day or equivalent) for longer th	an 2 weeks?	☐ Yes	□ No	☐ Don't know
15.	. Have you received a transfusion of blood or blood products or beer in the past year?	n given a medication called immune (gamma) globulin	□ Yes	□No	□ Don't know
16.	 Do you have a history of thymus disease (including myasthenia gra thymus removed? (yellow fever only) 	vis, DiGeorge syndrome or thymoma), or had your	☐ Yes	□No	☐ Don't know
17.	Do you have a history of thrombocytopenia or thrombocytopenic p	urpura? (MMR only)		☐ Yes	□ No	☐ Don't know
18.	. Have you consumed any food or drink in the last hour? (Vaxchora®	only)		□ Yes	□No	☐ Don't know
19.	. Have you taken antibiotics in the last 14 days or antimalarials in th	e last 10 days? (Vaxchora® only)		☐ Yes	□ No	☐ Don't know
C.	ECTION C					

I certify that I am: (a) the patient and at least 18 years of age: (b) the legal guardian of the patient; or (c) a person authorized to consent on behalf of the patient where the patient is not otherwise competent or unable to consent for themselves. Further, I hereby give my consent to Walgreens or Duane Reade and the licensed healthcare professional administering the vaccine, as applicable (each an "applicable Provider"), to administer the vaccine(s) I have requested above. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine(s) and have received, read and/or had explained to me the EUA Fact Sheet on the vaccine(s) I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. Further, I acknowledge that I have been advised that the patient should remain near the vaccination location for observation for approximately 15 minutes after administration. On behalf of the patient, the patient's heirs and personal representatives, I hereby release and hold harmless each applicable Provider, its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above. I acknowledge that: (a) I understand the purposes/benefits of my state's vaccination registry ("State Registry") and my state's health information exchange ("State HIE"); and (b) the applicable Provider may disclose my vaccination information to the State Registry, to the State HIE, or through the State HIE to the State Registry, or to any state or federal governmental agencies or authorities ("Government Agencies"), such as state, county, or local Departments of Health or the federal Department of Health and Human Services, the Centers for Disease Control and Prevention, or their respective designees as may be required by law, for purposes of public health reporting, or to my healthcare providers enrolled in the State Registry and/or State
HIE for purposes of care coordination. I acknowledge that, depending upon my state's law, I may prevent, by using a state-approved opt-out form or, as permitted by my state law, an opt-out form ("Opt-Out Form") furnished
by the applicable Provider: (a) the disclosure of my vaccination information by the applicable Provider to the State Registry or (b) the State HIE and/or State Registry from sharing my vaccination information in the State Registry and/or State HIE. The applicable Provider will, if my state permits, provide me with an Opt-Out Form. I understand that, depending on my state's law, I
may need to specifically consent, and, to the extent required by my state's law, by signing below, I hereby do consent to the applicable Provider reporting my vaccination information to the Government Agencies, State HIE, nearly need to specifically consent, and, to the extent required by in states haw, by signing below. I nereby out official to the applicable Provider the applicable Provider with a signed off-other information or through the State HIE and/or State Registry to the entities and for the purposes described in this Informed Consent form. Unless I provide the applicable Provider with a signed off-other with a signed my healthcare professionals, Medicare, Medicaid, or other third-party payer as necessary to effectuate care or payment; (b) submit a claim to my insurer for the above requested items and services; and (c) request payment of authorized benefits be made on my behalf to the applicable Provider with respect to the above requested items and services. I further agree to be fully financially responsible for any cost-sharing amounts, including copays, coinsurance and deductibles, for the requested items and services, as well as for any requested items and services not covered by my insurance benefits. I understand that any payment for which I am financially responsible is due at the time of service or, if the applicable Provider invoices me after the time of service, upon receipt of such invoice. Walgreens or its affiliates may contact you, including by autodialed and prerecorded calls and texts, at any time, using the contact information provided in your patient record regarding health and safety matters, such as vaccine reminders.

Patient signature:		Date:	
	(Parent or quardian if minor)		

Insurance Plan/Plan ID: Member/Recipient ID #: RX BIN: RX PCN: Group Number: Are you the cardholder? If no, please provide card date of birth (MM/DD/YY) SECTION E Complete BEFORE vac 1. I have reviewed the I 2. I have verified that the I 3. This vaccine is approand company policies 3a. Does this patient If yes, please list med If yes, please list med I have discussed with I 5. The Vaccine NDC non (Perform 3-way NI) 6. I have werified the Experience I have made every at I have made every at I have made every at I have asked the pation the VAR form.	□ Yes □ No dholder's name (Y) and relation this is the vaccopriate for this es. It have a high-redical condition the patient ac matches the No (DC match.) (piration Date	N/A N/A N/A N/A Stration rmation and cine requeste patient based isk medical conf(s): dditional immun NDC on the book is greater than	Med Last *Nur* †For COV If u Driv *For Hea I at H Screening Quee d by the patient on the Age Guid ndition? nizations the patient ottom of this VAR	dicare licare number:* : 4 digits of SSN:† mber on the red, white insurance confirmation /ID-19 VACCINAT uninsured: I attest the rest license/State ID verification and covera althcare provide tempted to obtain EALTHCARE P stions delines provided ent may be eligible form and the NE	and blue Medicare and blue Med	have any medirule one) dividual refusionce informati	ed to provide on from the in	insurance. Signification in the second secon	Yes ng state: here:
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Complete <u>AFTER</u> vacci	ine administi	ration	,	,	,			,	
Vaccine NDC	Manufactu	rer Dosage	Dose # (if applicable)	Site of Administration	Vaccine Lot #	Vaccine Expiration	Diluent Lot # (if applicable)	Diluent Expiration (if applicable	VIS/Pation Fact Sheet Published Date
Clinician's name (print): If applicable, intern/tec	:			Clinician signat	ure:			Title:stration date:	

Reminder

- $1. \quad \text{Update the patient's record with any new allergy, health condition or primary care provider information.} \\$
- 2. Enter vaccine lot #, expiration date and site of administration, then scan the VAR form into the patient's record.