Vaccine Administration Record (VAR) Informed Consent for Vaccination*

Medicare # - _ _ _ _- _____ **FLU OR PNEUMONIA VACCINES ONLY**

SECTION A *(Please print clearly)*

First name:_____Last name:_____

Date of birth:_____/_____/_____ Age:_____Gender: ☐ Female ☐ Male ☐ Other Phone: (_____)_____

Home address:_____City:_____State:_____ZIP: _____

I want to receive the following immunization(s) today:

Flu	Pneumonia	Shingles	Tdap	MMR	HPV	Meningitis	Chicken Pox
Hep A	Hep B	Typhoid	Japanese Encephalitis		Polio	Rabies	Yellow Fever

SECTION B The following questions will help us determine your eligibility to be vaccinated today.

All vaccines

1. Do you feel sick today? ☐Yes ☐No
2. Have you had a fever, cough or been outside of the country in the past 14 days? ☐Yes ☐No
3. Do you have allergies to latex, medications, food or vaccines? (Examples: eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal)? If yes, please list: ☐Yes ☐No
4. Have you ever had a reaction after receiving an immunization, including fainting or feeling dizzy? ☐Yes ☐No
5. Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-Barré Syndrome (a condition that causes paralysis) or other nervous system problem? ☐Yes ☐No
6. For women: Are you pregnant or considering becoming pregnant in the next month? ☐Yes ☐No

SECTION C

I certify that I am: (a) the patient and at least 18 years of age; (b) the parent or legal guardian of the minor patient; or (c) the legal guardian of the patient. Further, I hereby give my consent to the healthcare provider of The Prescription Shoppe as applicable 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 Vaccine Information Statements 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 to remain near the vaccination location for approximately 15 minutes after administration for observation by the administering healthcare provider. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless the 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 immunization registry ("State Registry") and my state's health information exchange ("State HIE"); and (b) the applicable Provider may disclose my immunization information to the State Registry, to the State HIE, or through the State HIE, to the State Registry, for purposes of public health reporting or to my health care providers enrolled in the State Registry and/or State HIE for purposes of care coordination. 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, the applicable Provider invoices me after the time of service, upon receipt of such invoice.

Patient signature: _____ **Date:** _____

(Parent or guardian, if minor)

Patient name: _____

Guardian Name/Relationship (if minor): _____

ADMIN ONLY

Immunizing Pharmacist Henry K. Ranger/ Jade L. Ranger/ Karanita Fuller Immunizing Pharmacist Signature _____

Vaccine(s)_____Dose: _____ Lot: _____ Exp: _____ Site: LA / R VIS Date: 8/6/21