Vaccine Administration Record (VAR) Informed Consent for Vaccination PHARMACY



,											
INFORMATION ABOUT PERSON RECEIVING VACCINE (PLEASE PRINT CLEARLY)											
Last Name Firs		First Name		Middle Initial		Birthdate	irthdate		Sex		
									□ M □ F		
Address				City		State/ZIP	/ZIP		Phone		
Medicare # (If Applicable)				Medicare Effective D	Date		MEDI-CAL	# (Optional)	ional)		
Physician Name Physician Phone							Physic	Physician Fax			
I request to have this information sent to the physician's office specified above.								Пү	☐ Yes ☐ No		
Which vaccines are you requesting to have administered today?											
□ Diphtheria, Tetanus and Pertussis (DTap) □ Hepatitis A □ Hepatitis B □ HPV (Human Papillomavirus) Cervarix® □ HPV (Human Papillomavirus) Gardasil® □ Inactivated influenza (standard flu shot) □ Other: □ MMR (Measles, Mumps and Rubella) □ MMRV (Measles, Mumps, Rubella and Varicella) □ Meningococcal □ MMR (Measles, Mumps, Rubella and Varicella) □ Meningococcal □ Pneumococcal Conjuate (PCV13) □ Pneumococcal Conjuate (PCV13) □ Pneumococcal Polysaccharide □ Polio □ Other:										Pertussis)	
The	e following questions will he	elp us determir	e your eligibility to	be vaccinated too	lay.			Yes	No	Don't Know	
	1. Do you feel sick today?										
ALL VACCINES	2. Do you have allergies to medications, food or vaccines? (Examples: eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol or thimerosol) If yes, please list:										
	3. Have you received any vaccinations or skin tests in the past four weeks? If yes, please list:										
	4. Have you ever had a serious reaction to an influenza vaccine or any other vaccine in the past?										
	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?										
	6. Are you 65 years of age or older?										
	7. Do you smoke?										
	8. Do you have a chronic condition or long-term health problem? If yes, please check all that apply. Anemia Asthma Diabetes Heart disease Kidney disease Liver disease Lung disease Other:										
	9. If you answered YES to question 6, 7 or 8, have you ever had a pneumonia vaccination?										
	10. Have you ever had a shingles vaccination (for patients 60 years of age and older only)?										
	11. Are you a healthcare worker?										
	12. For women: Are you pregnant or considering becoming pregnant in the next month?										
S	13. Are you currently on home infusions, weekly injections, steroid therapy, anticancer drugs or radiation treatments?										
LIVE VACCINES	14. Do you have cancer, leukemia, lymphoma, HIV/AIDS or any other immune system disorder or are you in contact with anyone who has a severely weakened immune system?										
	15. Have you received a transfusion of blood or blood products or been given a medicine called immune (gamma) globulin in the past year?										
}	16. Are you receiving aspirin therapy or aspirin-containing therapy (18 years of age and younger only)?										
Loertify that I am: (i) the patient and at least 18 years of age; (ii) the parent or legal guardian of the minor patient; or (iii) the legal guardian of the patient. Further, I hereby give my consent to Hoover Pharmacy, as applicable, to administrate 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 Hoover Pharmacy, as applicable, 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 authorize Hoover Pharmacy, as applicable, to (1) release my medical and other information, including my communicable disease (including HIV), mental health and drug/alcohol abuse information to my healthcare professionals, Medicare, Medicaid or other third-party payer as necessary to effectuate care or payment, (2) submit a claim to my insurer for the above requested items and services and (3) request payment of authorized benefits to be made on my behalf to Hoover Pharmacy, as applicable, with respect to the above requested items and services to tovered by my insurance benefits. In understand that any payment for which I am financially responsible is due at the time of service o											
Patient Signature (Parent or Guardian if Minor): Date:											
THI	E FOLLOWING SECTION IS I	FOR PHARMAG	CY USE ONLY								
Immunizer Name (Print):											
If Apı	olicable, Intern Name (Print):			Administration Dat	ie:		_ Date VIS Gi	ven to Patient:			
Vaccine I		Lot#	Exp Date	Manufacturer	Dosage	Circle Site of In	jection	VIS Date	RPh Pr	e-fill Initials	

Inactivated influenza

CAIR Notice **VIS Given** RPh Initial

Deltoid

IM