Vaccine Administration Record (VAR)—Informed Consent for Vaccination

Store number:_____
Rx number:_____
Store address:_____

NOTE: A copy of the completed "VACCINE ADMINISTRATION RECORD (VAR) INFORMED CONSENT FOR VACCINATION" form is to be furnished to the patient or the patient's guardian or representative at the conclusion of the vaccination encounter with the ATTESTATION on the last page to be completed AFTER the copy is made.

SECTION A Please print clearly.

First name: _____ **Last name:** _____

Date of birth: _____ **Age:** _____ **Gender:** ☐ Female ☐ Male **Phone:** _____

Home address: _____ **City:** _____

State: _____ **ZIP code:** _____ **Email address:** _____

Race: ☐ American Indian or Alaska Native ☐ Asian Native Hawaiian or Other Pacific Islander ☐ Black or African American ☐ White ☐ Other Race _____ ☐ Unknown

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ethnicity

I want to receive the following vaccination(s): _____

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	☐ Don't know
2.	Have you been diagnosed with or tested positive for COVID-19 in the last 14 days?	☐ Yes	☐ No	☐ Don't know
3.	In the past 14 days have you been identified as a close contact to someone with COVID-19?	☐ Yes	☐ No	☐ Don't know
4.	Do you have a history of allergic reaction or allergies to latex, medications, food or vaccines (examples: polyethylene glycol, polysorbate, eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal)? If yes, please list: _____	☐ Yes	☐ No	☐ Don't know
5.	Have you ever had a reaction after receiving a vaccination, including fainting or feeling dizzy?	☐ Yes	☐ No	☐ Don't know
6.	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	☐ Don't know
7.	Have you received any vaccinations or skin tests in the past eight weeks? If yes, please list: _____	☐ Yes	☐ No	☐ Don't know
8.	Have you ever received the following vaccinations? ☐ Pneumonia: Date received _____ ☐ Shingles: Date received _____ ☐ Whooping cough: Date received _____			
9.	Do you have any chronic health condition such as cancer, chronic kidney disease, immunocompromised, chronic lung disease, obesity, sickle cell disease, diabetes, heart disease? If yes, please list: _____	☐ Yes	☐ No	☐ Don't know
10.	For women: Are you pregnant or considering becoming pregnant in the next month?	☐ Yes	☐ No	☐ Don't know
11.	**For COVID-19 vaccine only**: Have you been treated with antibody therapy specifically for COVID-19 (monoclonal antibodies or convalescent plasma)?	☐ Yes	☐ No	☐ Don't know
	For chickenpox, MMR® II, shingles, Vaxchora®, yellow fever only: Answer the following questions only if you are receiving any vaccinations listed above.			
12.	Do you have a condition that may weaken your immune system (e.g., cancer, leukemia, lymphoma, HIV/AIDS, transplant)?	☐ Yes	☐ No	☐ Don't know
13.	Are you currently on home infusions, weekly injections such as Humira® (adalimumab), Remicade® (infliximab) or Enbrel® (etanercept), high-dose methotrexate, azathioprine or 6-mercaptopurine, antivirals, anticancer drugs or radiation treatments?	☐ Yes	☐ No	☐ Don't know
14.	Are you currently taking high-dose steroid therapy (prednisone > 20mg/day or equivalent) for longer than 2 weeks?	☐ Yes	☐ No	☐ Don't know
15.	Have you received a transfusion of blood or blood products or been given a medication called immune (gamma) globulin in the past year?	☐ Yes	☐ No	☐ Don't know
16.	Do you have a history of thymus disease (including myasthenia gravis, DiGeorge syndrome or thymoma), or had your thymus removed? (yellow fever only)	☐ Yes	☐ No	☐ Don't know
17.	Do you have a history of thrombocytopenia or thrombocytopenic purpura? (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 the last 10 days? (Vaxchora® only)	☐ Yes	☐ No	☐ Don't know

SECTION C

I certify that I am:

_____ Provider Initials acknowledging this clause.

(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 declare that I am **UNDER DURESS AND/OR UNDER THREAT OF FINANCIAL SANCTION, THE POTENTIAL LOSS OF MY EMPLOYMENT, THE INABILITY OF THE PATIENT TO ATTEND SCHOOL, or otherwise believe that I or the patient will be unable perform activities necessary for or legally required unless I** give my consent to be vaccinated. Therefore, under such threat and duress, I consent to _____ 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.

_____ Provider Initials acknowledging this clause.

On behalf of the patient, the patient's heirs and personal representatives, I ***expressly DO NOT*** release and hold harmless any 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.

_____ Provider Initials acknowledging this clause.

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) ***DO NOT PERMIT*** the applicable Provider to 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 *unless required by law*, nor to my healthcare providers enrolled in the State Registry and/or State HIE for any purpose.

_____ Provider Initials acknowledging this clause.

I hereby ***request 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 to opt out and ***I seek to prevent***: (a) the disclosure of my vaccination information by the applicable Provider to the State HIE and/or State Registry; or (b) the State HIE and/or State Registry from sharing my vaccination information with any of my other healthcare providers enrolled in the State Registry and/or State HIE. The applicable Provider will, if my state permits, provide me with an Opt-Out Form.

_____ Provider Initials acknowledging this clause.

I DO NOT consent, to the applicable Provider reporting my vaccination information to the Government Agencies, State HIE, or through the State HIE and/or State Registry or to any other party for any purpose unless REQUIRED BY LAW or such consent is given separately in writing by me.

_____ Provider Initials acknowledging this clause.

I understand that even though I do not consent or if I withdraw my consent, my state's laws or federal law may require certain disclosures of my vaccination information to or through the State HIE or to Government Agencies as required by law, but ***I DO NOT CONSENT*** to disclosures merely "permitted" by law.

_____ Provider Initials acknowledging this clause.

I further ***DO NOT AUTHORIZE*** the applicable Provider to release my medical or other information, including any communicable disease (including HIV) and mental health information, to, or through, the State HIE or Government Agencies to my healthcare professionals, Medicare, Medicaid, or other third-party payer except as expressly required by law or as necessary to effectuate care or payment. *If the disclosure is to effectuate care or payment, applicable Provider shall report to me in writing at least 15 days prior to such disclosure the reason that the disclosure is necessary and provide me an opportunity to prevent such disclosure.* I ***DO AUTHORIZE*** the applicable provider to: (a) submit a claim to my insurer for the above requested items and services; and (b) 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.

_____ Provider Initials acknowledging this clause.

I do not consent or permit _____ or its affiliates to contact me using the contact information provided in your patient record by any autodialed or prerecorded calls or texts, at any time, or for any reason unless authorized by me separately.

Patient signature: _____ Date: _____

(Parent or guardian, if minor)

Provider signature: _____ Date: _____

SECTION D INSURANCE–PATIENT OR AUTHORIZED PERSON TO COMPLETE

Please ensure to record BOTH pharmacy AND medical insurance information since there are multiple ways vaccinations can be billed.

	Pharmacy card	Medical card
Insurance Plan/Plan ID:		
Member/Recipient ID #:		
RX BIN:		N/A
RX PCN:		N/A
Group Number:		

Are you the cardholder? ☐ Yes ☐ No
If no, please provide cardholder's name, date of birth (MM/DD/YYY) and relationship: _____

Medicare	Medicare Part B
Medicare number:*	
Last 4 digits of SSN:†	

*Number on the red, white and blue Medicare card.
†For insurance confirmation purposes only.

COVID-19 VACCINATION ONLY

If uninsured: I attest that I do not have any medical or pharmacy insurance. ☐ Yes

Drivers license/State ID number* (circle one) _____ Issuing state: _____
*For verification and coverage Initial here: _____

Healthcare provider only: Individual refused to provide insurance information when I attempted to obtain the insurance information from the individual. ☐ Yes

SECTION E HEALTHCARE PROVIDER ONLY

Complete <u>BEFORE</u> vaccine administration

a. I acknowledge that the patient has provided consent UNDER DURESS AND FEELS COERCED OR THREATENED. Initial here: _____

1. I have reviewed the **Patient Information and Screening Questions.** Initial here: _____
2. I have verified that this is the **vaccine requested** by the patient. Initial here: _____
3. This vaccine is appropriate for this patient based on the **Age Guidelines** provided by federal and/or state regulations and company policies. Initial here: _____

   3a. Does this patient have a high-risk medical condition? ☐ Yes ☐ No
   If yes, please list medical condition(s): _____
4. I have discussed with the patient additional immunizations the patient may be eligible for based on age and/or health conditions Initial here: _____
5. The **Vaccine NDC matches** the NDC on the bottom of this VAR form and the NDC on the patient leaflet. (**Perform 3-way NDC match**.) Initial here: _____
6. I have verified the **Expiration Date** is greater than today's date and have entered the **Lot # and Expiration Date** in the field below. Initial here: _____
7. I have made every attempt to obtain and confirm patient insurance information Initial here: _____

For COVID-19, Shingrix®, MMR® II, Varivax®, YF-Vax®, Menveo®, Imovax®, Vaxchora® and RabAvert®, ensure the vaccine is reconstituted following the package insert's instructions.

SECTION F

Complete <u>DURING</u> the patient interaction

1. I have asked the patient ***<u>if their consent to be vaccinated "is free and voluntary without any threat or coercion."</u>*** The patient replied: _____ Initial here: _____
2. I have asked the patient to confirm their **Name, DOB and Requested Vaccine** and verified it matches the information on the VAR form. Initial here: _____
3. I have reviewed the **Screening Questions** with the patient. Initial here: _____
4. I have reviewed the **VIS/Patient Fact Sheet** with the patient. Initial here: _____

Notes

Reminder

1. 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.

SECTION G

Complete AFTER vaccine administration

Vaccine	NDC	Manufacturer	Dosage	Dose # (if applicable)	Site of Administration	Vaccine Lot #	Vaccine Expiration	Diluent Lot # (if applicable)	Diluent Expiration (if applicable)	VIS/Patient Fact Sheet Published Date

SECTION H

Completed by provider refusing to vaccinate the patient

I _____ do hereby refuse to vaccinate the named patient for the reason(s) below:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Clinician's name (print): _____ **Clinician signature:** _____ **Title:** _____

Date: _____

Signature

Clinician's name (print): _____ **Clinician signature:** _____ **Title:** _____

If applicable, intern/tech name (print): _____ **Administration date:** _____

Date EUA Fact Sheet/VIS given to patient: _____

ATTESTATION OF COPY (To be signed AT THE END of the encounter – AFTER copies of the VAR have been made)

I do hereby swear, affirm, and attest that this is a full and complete copy of the original "VACCINE ADMINISTRATION RECORD (VAR) – INFORMED CONSENT FOR VACCINATION" form created on this date and for the encounter described.

Clinician

Name (print): _____ **Signature:** _____ **Title:** _____

Date: ____ / ____ / 20____ **Time:** ____ : ____ AM / PM

Patient or Patient Representative

Name (print): _____ **Signature:** _____

Date: ____ / ____ / 20____ **Time:** ____ : ____ AM / PM