Student Health Center Pharmacy
by KEYSTONE PHARMACY SERVICES

Vaccine Administration Record (VAR) Informed Consent for Vaccination For All Health Care Providers*
PATIENT: COMPLETE SECTIONS A,B,C

SECTION A **(PLEASE PRINT CLEARLY)**

Cell Phone ____ ____ ____ Date of Birth ____ ____ ____ Age ____ Gender ____ Male ____ Female

First Name ____ MI ____ Last Name ____

Home Address ____ City ____ State ____ Zip Code ____

Primary Care Physician Name ____ Physician Phone ____ ____ ____

SECTION B The following questions will help us determine your eligibility to be vaccinated today. For All Vaccines: Please answer questions 1-9. For Live Vaccines: (e.g. Live Attenuated Influenza Nasal Spray or Zostavax): Please answer questions 1-16.

KNOW		**YES**	**NO**	**DON'T**
1.	Which vaccines are you requesting to have administered today? (PLEASE CIRCLE) **1) FLU** **2) PNEUMONIA**			
2.	Do you feel sick today?	___	___	___
3.	Do you have allergies to medications, food or any vaccine? (EX. Eggs, Bovine Protein, Gelatin, Gentamycin, Polymyxin, Neomycin, Phenol or Thimerosal) **If Yes, Please List:**	___	___	___
4.	Have you received any vaccinations in the past 4 weeks**? If yes, Please list:**	___	___	___
5.	Have you ever had a serious reaction to an Influenza vaccine or any other vaccine in the past?	___	___	___
6.	Have you ever had a seizure disorder for which you take seizure medication(s),a brain disorder, Guillain-Barre Syndrome, or other nervous system problem?	___	___	___
7.	Are you 65 years of age or older OR do you smoke OR have a chronic condition like asthma or diabetes?	___	___	___
8.	If you answered YES to question #7, have you ever had a pneumococcal, or "pneumonia" vaccination?	___	___	___
	For Women: Are you pregnant or considering becoming pregnant in the next month?	___	___	___

---------- **STOP HERE IF YOU ARE RECEIVING INACTIVATED INFLUENZA OR PNEUMOCOCCAL**----------

SECTION C

I certify 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 the health care provider of Keystone Pharmacy Services, D/B/A UT Student Health Center Pharmacy or an employee of the University of Tennessee to administer the vaccine 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 associated Vaccine Information Sheet and have had time to ask any questions that I may have had. I have also been instructed to remain in near the vaccination location for 15 minutes after my vaccination for observation by the administering healthcare provider. On my behalf, I hereby release Keystone Pharmacy Services D/B/A UT Student Health Center Pharmacy or the University of Tennessee, as applicable, 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.

SIGNATURE:_____ **DATE:**_____

SECTION D (HEALTH CARE PROVIDERS ONLY) *The following section is to be completed by the health care provider only.*

Immunizer Name (Print):_____
Immunizer Signature:_____RPH/PharmD/Intern/MD/RN/LPN

Vaccine	**Lot#**	**Exp. Date**	**Manufacturer**	**Dosage**	**Injection Site**	**VIS Date**
Fluvirin 2015-2016	1514801	05/30/2016	Novartis	0.5 mL	L / R Deltoid IM	_____
Pneumovax 23	K009105	01/21/2016	Merck & Co	0.5 ml	L / R Deltoid IM	_____