Vaccine Administration Record (VAR) Informed Consent for Vaccination for All Healthcare Providers*

PATIENT: COMPLETE SECTIONS A, B, C

SECTION A (Please print clearly.)

First Name: ______________________ **Last Name:** __________________________ **Date of Birth:** _______________ **Age:** ______

Gender: ☐ Female ☐ Male **Home Phone:** __________________________ **Cell Phone:** ____________________________

Home Address: ____ **City:** _________________ **State:** _______ **Zip:** _____________

Primary Care Physician/Provider Name: ____________________________________ **Phone Number:** _______________________

Medicare Part B Number (if applicable): __________________________

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

SECTION B

The following questions will help us determine your eligibility to be vaccinated today. For all vaccines, please answer questions 1-8. For live vaccines (e.g. MMR or Shingles), please answer questions 1-12. For Flu nasal spray, please answer questions 1-14.

All Vaccines

1. Are you currently sick with a moderate to high fever, vomiting/diarrhea? ☐ Yes ☐ No ☐ Don't Know
2. Have you ever fainted or felt dizzy when receiving an immunization? ☐ Yes ☐ No ☐ Don't Know
3. Have you ever had a serious reaction after receiving an immunization? ☐ Yes ☐ No ☐ Don't Know
4. Are you 19 years of age or older with an immunocompromising condition, functional or anatomic asplenia, CSF leak, or cochlear implant? ☐ Yes ☐ No ☐ Don't Know
5. Do you have allergies to medications, food or vaccines? (Examples: eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal) ☐ Yes ☐ No ☐ Don't Know
   a. If Yes, please list: ____
6. Have you received any vaccinations or skin tests in the past four weeks? ☐ Yes ☐ No ☐ Don't Know
   a. If Yes, please list: ____
7. Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Gullian-Barré Syndrome or other nervous system problems? ☐ Yes ☐ No ☐ Don't Know
8. **For women:** Are you pregnant or considering becoming pregnant in the next month: ☐ Yes ☐ No ☐ Don't Know

Live Vaccines (Flu nasal spray, Shingles) Only answer these questions if you are receiving these two immunizations.

9. Are you currently on home infusions, weekly injections (such as adalimumab, infliximab and etanercept), high-dose methotrexate, azathioprine or 6-mercaptopurine, antivirals, anticancer drugs or radiation treatments? ☐ Yes ☐ No ☐ Don't Know
10. Do you have cancer, leukemia, lymphoma, HIV/AIDS or any other immune system disorder? ☐ Yes ☐ No ☐ Don't Know
11. Have you received a transfusion of blood or blood products or been given a medicine called immune (gamma) Globulin in the past year? ☐ Yes ☐ No ☐ Don't Know
12. Are you currently taking high-dose steroid therapy (prednisone >20mg/day) for longer than two weeks? ☐ Yes ☐ No ☐ Don't Know

Flu Nasal Spray (FluMist®)

13. For patients 18 years of age and younger only: Are you receiving aspirin therapy or aspirin-containing therapy? ☐ Yes ☐ No ☐ Don't Know
14. Do you have a nasal condition serious enough to make breathing difficult, such as a very stuffy nose? ☐ Yes ☐ No ☐ Don't Know

SECTION C

I certify that I am: (1) the Patient and at least 18 years of age; (2) the parent or legal guardian of the minor Patient; or (3) the legal guardian of the Patient. Further, I hereby give my consent to the healthcare provider of the University of Nevada School of Medicine, 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/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 answer4ed 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 health provider. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless University of Nevada School of Medicine, 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 acknowledge that (a) I understand the purpose/benefits of my state's immunization registry ("Registry"); (b) I may, if my state permits, object to the University of Nevada School of Medicine disclosing my immunization information to the Registry by providing the University of Nevada School of Medicine with a state approved Registry disclosure opt out form (which I may request and obtain from the University of Nevada School of Medicine Campus Pharmacy, if permitted by my state); and (c) Unless I authorize the University of Nevada School of Medicine, as applicable, to (i) release my medical or 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, (ii) submit a claim to my insurer for the above requested items and services, and (iii) request payment of authorized benefits be made on my behalf to University of Nevada School of Medicine Campus Pharmacy, Inc., as applicable, with respect to the above requested items and services. I further agree to be fully financially responsible for any co-sharing amounts, including co-pays, 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 University of Nevada School of Medicine, invoices me after the time of service, upon receipt of such invoice.

Signature: ____ **Date:** ________________________

(Parent or Guardian, if minor)

*Healthcare Provides can be an immunization certified pharmacist or a registered nurse, licensed practical nurse, licensed vocational nurse, nurse practitioner or physician's assistant.

SECTION D	HEALTHCARE PROVIDER ONLY

Complete **BEFORE** vaccine administration.

Vaccine	Route/Site	Dosage	Lot #	Expiration Date	VIS Published Date
Influenza Tri Quid HD	IM LD RD	0.5mL			
Influenza (Nasal)	Intranasal	0.1mL each nostril			
Pneumococcal (Pneumonia)	Intramuscular	0.5mL			
PCV13	IM LD RD	0.5mL			
PPSV23					
Shingles (Hepes Zoster)	SQ L R				
Tdap (Tetanus, diphtheria and pertussis)	IM LD RD				

Immunizer Name (print): ____________________________________ **Immunizer Signature:** ______________________________ **Date:** ___________

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