



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

SECTION A Please print clearly.

Home Phone, Date of Birth, Age, Gender, First Name, MI, Last Name, Home Address, City, State, Zip Code, Email Address, Medicare Part B Number, Primary Care Physician Name, Physician Phone, Physician Address, City, State

SECTION B The following questions will help us determine your eligibility to be vaccinated today. For All Vaccines: Please answer questions 1-12. For Live Vaccines (e.g. Flu Nasal Spray or Shingles): Please answer questions 1-19.

YES NO DON'T KNOW

Table with 3 columns (Question, YES, NO, DON'T KNOW) and rows for ALL VACCINES (1-12) and LIVE VACCINES (13-19). Questions include: 1. Which vaccines are you requesting... 2. Do you feel sick today? 3. Do you have allergies... 4. Have you received any vaccinations... 5. Have you ever had a serious reaction... 6. Have you ever had a seizure disorder... 7. Are you 65 years of age or older? 8. Do you smoke? 9. Do you have a chronic condition... 10. If you answered YES to question #7, 8 or 9... 11. Are you a health care worker? 12. For women: Are you pregnant... 13. Do you have cancer... 14. Are you currently on home infusions... 15. Do you take cortisone... 16. Have you received a transfusion... 17. Are you receiving aspirin therapy... 18. If the patient receiving vaccine is under 5 years old... 19. Does the patient have a nasal condition...

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 Walgreens or Take Care Health Services, 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 health care provider. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless Walgreens or Take Care Health Services, 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 purposes/benefits of my state's immunization registry ("Registry"); (b) I may, if my state permits, object to Walgreens disclosing my immunization information to the Registry by providing Walgreens with a state approved Registry disclosure opt out form (which I may request and obtain from Walgreens, if permitted by my state); and (c) unless I provide Walgreens with an approved opt out form, I have elected to participate in the Registry and consented to Walgreens reporting my immunization information. I authorize Walgreens or Take Care Health Services, 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 health care professionals, Medicare, Medicaid, or other third party payor 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 Walgreens or Take Care Health Services, 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 Walgreens or Take Care Health Services invoices me after the time of service, upon receipt of such invoice.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_ (Parent or Guardian, if minor)

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

Table with 8 columns: Vaccine, Lot #, Exp Date, Manufacturer, Dosage, Circle Site of Injection, VIS Date, Date PNL Sent. Rows include: Inactivated influenza -PF, Pneumococcal polysaccharide.

\*Health care providers can be an immunization certified pharmacist or a registered nurse, licensed practical nurse, licensed vocational nurse, nurse practitioner or physician's assistant. \*\*Patient care services at Take Care Clinics are provided by Take Care Health ServicesSM, an independently owned professional corporation whose licensed healthcare professionals are not employed by or agents of Walgreen Co. or its subsidiaries, including Take Care Health SystemsSM, LLC.