## **Walgreens** There's a way to stay well.



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

Home Phone       Date of Birth       Age       Gender         First Name       Mil       Last Name       Male       Female         Primary Care Physician Name (If known)       Physician Address       Medicare Part B Number (If applicable)         Primary Care 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.       YES       NO       DONT         Pri Low Vaccines (bg., Flu Nass Spray (Fisc - ages 2 to 49 only)       Pneumonia       Shingles       Other	SECTION A		Please print clearly.																																											
First Name       Mil       Last Name         Home Address       City       State       Zip Code         Email Address       Medicare Part B Number (if applicable)       Medicare Part B Number (if applicable)         Primary Care Physician Address       City       State       State         SECTION B. The following questions will help us determine your eligibility to be vaccinated today. For Al Vaccines: Please answer questions 1-12.       YES       NO       DOWT         SECTION B. The following questions will help us determine your eligibility to be vaccinated today. For Al Vaccines: Please answer questions 1-12.       YES       NO       DOWT         Vestor Law Vaccines (e.g., Put Massi Daryor of Singles): Please answer questions 1-13.       YES       NO       DOWT         *       Full bot       Full Naccines: Please answer questions 1-12.       YES       NO       DOWT         *       Number of a spray of Singles): Please answer questions 1-12.       YES       NO       DOWT       NO         *       Full bot       Full Nasal Spray of Singles (and dary Please answer questions):       Image: Singles (and dary Please answer questions):       Image: Single (and dary Please answer questions):       Imag	Home Phone				_	_	_					Date of Birth			th					_	Age				Gender										/	/										
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10. Does the nationt have a nasel condition serious anough to make breathing difficult such as a very stuffy nose? (for ElyMist® only)	5	18	3. It	the	pa	ient	rece	eiving	g vac	cine	e is u	nder	5 ye	ars (	old, d	does	he/s	she h	ave	a hi	stor	y of	asth	ima (	or w	heez	ng?	(for F	luM	list®	only	)														
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SECTION C

Locrtify 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) 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 bene avised to remain near the vaccine(s) have elected to receive. I also acknowledge that: (a lunderstand the purposes/benefits of my stels) renain near the vaccine information of 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 with an approved opt out form, I have elected to participate in the Registry and consented to Walgreens reporting my immunization. I authorize Walgreens or Take Care Health Services, as applicable, it requested items and services. I further agree to be fully financially responsible for any co-sharing amounts, including co-pays, coin

Patient Signature: \_

(Parent or Guardian, if minor)

Date: \_\_

SECTION D (HEALTH CARE PROVIDERS ONLY) The following section is to be completed by the health care provider only.															
Immunizer Name (print):		Immunize	r Signature:												
If applicable, Intern Name (print):		A	dministration Date:		Date VIS given to Patient:										
Vaccine	Lot #	Exp Date	Manufacturer	Dosage	<b>Circle Site of Injection</b>	VIS Date	Date PNL Sent								
Inactivated influenza -PF				0.5 ml	L/R Deltoid IM										
Pneumococcal polysaccharide				0.5 ml	L/R Deltoid IM										

\*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 Services<sup>SM</sup>, 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 Systems<sup>SM</sup>, LLC. **IMMUNIZATION**