Vaccine Administration Record (VAR) Informed Consent for Vaccination for all healthcare providers*

Walgreens healthcare clinic† at select Walgreens

PATIENT: COMPLETE SECTIONS A, B, C

PROVIDER: COMPLETE SECTION D (reverse side)

STORE STAMP

SECTION A

(Please print clearly.)

First name: _____ **Last name:** _____ **Date of birth:** _____ **Age:** _____

Gender: ☐ Female ☐ Male **Home phone:** _____ **Mobile phone:** _____

Race (select one or more)

☐ Native American or Alaska Native ☐ Asian ☐ Black or African-American ☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Other

Ethnicity (select one)

☐ Hispanic or Latino ☐ Not Hispanic or Latino

Home address: _____ **City:** _____ **State:** _____ **ZIP code:** _____

Email address: _____

Doctor/primary care provider name: _____ **Phone number:** _____

Address: _____ **City:** _____ **State:** _____ ☐ I do not have a primary care doctor/provider

I want to receive the following immunization(s):

☐ Flu (influenza) ☐ Pneumonia (pneumococcal) ☐ Shingles (herpes zoster) ☐ Tdap (whooping cough) ☐ Other: _____

SECTION B

The following questions will help us determine your eligibility to be vaccinated today. For all vaccines: Please answer questions 1-7. For live vaccines (e.g., MMR or shingles): Please answer questions 1-14. For flu nasal spray: Please answer questions 1-17.

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 after receiving an immunization?	☐ Yes	☐ No	☐ Don't know
3.	Have you ever had a reaction after receiving an immunization?	☐ Yes	☐ No	☐ Don't know
4.	Do you have an immunocompromising condition (e.g., cancer, leukemia, lymphoma, HIV/AIDS, transplant), functional, or anatomic asplenia, CSF leak or cochlear implant?	☐ Yes	☐ No	☐ Don't know
5.	Do you have allergies to latex, medications, food or vaccines? (Examples: eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal) a. If yes, please list: _____	☐ Yes	☐ No	☐ Don't know
6.	Have you ever had a seizure disorder for which you are on seizure medications, a brain disorder, Guillain-Barré syndrome or other nervous system problems?	☐ Yes	☐ No	☐ Don't know
7.	**For women:** Are you pregnant or considering becoming pregnant in the next month?	☐ Yes	☐ No	☐ Don't know
Live vaccines (Chicken pox, flu nasal spray, MMR, oral typhoid, shingles, Yellow fever) Only answer these questions if you are receiving any immunization listed above.				
8.	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
9.	Have you received any vaccinations or skin tests in the past four weeks? a. If yes, please list: _____	☐ Yes	☐ No	☐ Don't know
10.	Have you received a transfusion of blood, blood products or been given a medication called immune (gamma) globulin in the past year?	☐ Yes	☐ No	☐ Don't know
11.	Are you currently taking high-dose steroid therapy (prednisone >20mg/day or equivalent) for longer than two weeks?	☐ Yes	☐ No	☐ Don't know
12	Do you have a history of thymus disease (including myasthenia gravis), thymoma or prior thymectomy? (Yellow fever only)	☐ Yes	☐ No	☐ Don't know
13.	Are you currently taking any antibiotics or antimalarial medications? (Oral typhoid only)	☐ Yes	☐ No	☐ Don't know
14.	Do you have a history of thrombocytopenia or thrombocytopenic purpura? (MMR only)	☐ Yes	☐ No	☐ Don't know
Flu nasal spray (FluMist® Quadrivalent)				
15.	For patients 18 years of age and younger only: Are you receiving aspirin therapy or aspirin-containing therapy?	☐ Yes	☐ No	☐ Don't know
16.	For patients 5 years of age and younger only: Is there a history of asthma or wheezing?	☐ Yes	☐ No	☐ Don't know
17.	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: (a) the patient and at least 18 years of age; (b) the parent or legal guardian of the minor patient; or (c) the legal guardian of the patient. Further, I hereby give my consent to the healthcare 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 healthcare 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 ("State Registry") and my state's health information exchange ("State HIE"); and (b) Walgreens or Take Care Health Services℠, as applicable, may disclose my immunization information to the State Registry, to the State HIE, or through the State HIE, to the State Registry, for purposes of public health reporting or to my health care providers enrolled in the State Registry and/or State HIE for purposes of care coordination. I acknowledge that, depending upon my state's law, I may prevent, by using a state-approved opt-out form or, as permitted by my state law, a Walgreens or Take Care Health Services℠ opt-out form ("Opt-Out Form"): (a) the disclosure of my immunization information by Walgreens or Take Care Health Services℠ to the State HIE and/or State Registry; or (b) the State HIE and/or State Registry from sharing my immunization information with any of my other healthcare providers enrolled in the State Registry and/or State HIE. Walgreens or Take Care Health Services℠, as applicable, will, if my state permits, provide me with an Opt-Out Form. I understand that, depending on my state's law, I may need to specifically consent, and to the extent required by my state's law, by signing below, I hereby do consent to Walgreens or Take Care Health Services℠, as applicable, reporting my immunization information to the State HIE, or through the State HIE and/or State Registry to the entities and for the purposes described in this Informed Consent form. Unless I provide Walgreens or Take Care Health Services℠, as applicable, with a signed Opt-Out Form, I understand that my consent will remain in effect until I withdraw my permission and that I may withdraw my consent by providing a completed Opt-Out Form to Walgreens, Take Care Health Services℠ and/or my State HIE, as applicable. I understand that even if I do not consent or if I withdraw my consent, my state's laws may permit certain disclosures of my immunization information to or through the State HIE as required or permitted by law. I also authorize Walgreens or Take Care Health Services℠, as applicable, to disclose my, or my child's (or unemancipated minor for whom I am authorized to act as guardian or in loco parentis) proof of immunization to the school where I am, or my child (or unemancipated minor for whom I am authorized to act as guardian or in loco parentis) is, a student or prospective student. I further authorize Walgreens or Take Care Health Services℠, as applicable, to (a) release my medical or other information, including my communicable disease (including HIV), mental health and drug/alcohol abuse information, to, or through, the State HIE to my healthcare professionals, Medicare, Medicaid, or other third-party payer as necessary to effectuate care or payment, (b) submit a claim to my insurer for the above requested items and services, and (c) 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 cosharing 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 Walgreens or Take Care Health Services℠ invoices me after the time of service, upon receipt of such invoice.**

Signature: _____ **Date:** _____

(Parent or guardian, if minor)

*Healthcare providers can be an immunization-certified pharmacist or a registered nurse, licensed practical nurse, licensed vocational nurse, nurse practitioner, physician or physicians assistant.

†Patient care services at Healthcare Clinic at select Walgreens provided by Take Care Health Services, 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, LLC. Walgreen Co. and its subsidiary companies provide management services to provider practices, in-store clinics and worksite health and wellness centers.

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

SECTION D HEALTHCARE PROVIDER ONLY

Complete BEFORE vaccine administration

Vaccine	Route	Dosage	Lot #	Expiration date
Influenza	intramuscular	0.25mL: 24-36 months 0.5mL: >36 months		
Influenza (intradermal)	intradermal	0.1mL (prefilled)		
Influenza (nasal)	intranasal	0.1mL each nostril		
Influenza (high dose)	intramuscular	0.5mL (prefilled)		
Chicken pox (varicella)	subcutaneous	0.5mL		
Hepatitis A	intramuscular	1mL: Adults ≥19 years 0.5mL: Adolescents ≤ 18 years		
Hepatitis B	intramuscular	1mL: Adults ≥20 years 0.5mL: Adolescents ≤ 19 years		
Hepatitis A/B (Twinrix®)	intramuscular	1mL: Adults ≥18 years		
Human papillomavirus	intramuscular	0.5mL		
Japanese encephalitis	intramuscular	0.5mL		
Meningococcal (meningitis)	intramuscular (subcutaneous – Menomune® only)	0.5mL		
MMR (measles, mumps, rubella)	subcutaneous	0.5mL		
Pneumococcal (Pneumovax®)	intramuscular	0.5mL		
Pneumococcal (Prevnar®)	intramuscular	0.5mL (prefilled)		
Polio	intramuscular	0.5mL		
Rabies	intramuscular	1mL		
Shingles (herpes zoster)	subcutaneous	0.65mL		
Td (tetanus and diphtheria)	intramuscular	0.5mL		
Tdap (tetanus, diphtheria and pertussis)	intramuscular	0.5mL		
Typhoid (live oral)	orally	1 capsule by mouth every other day until all taken		
Typhoid (inactive injectable)	intramuscular	0.5mL		
Yellow fever	subcutaneous	0.5mL		

Needle size	Patient gender/weight
Intramuscular injection is in the deltoid	
⅝‡ to 1 inch needle	Female or male weighing less than 130 lbs
1 to 1½ inch needle	Female 130-200 lbs; male 130-260 lbs
1½ inch needle	Female 200+ lbs; male 260+ lbs
Subcutaneous injection is in the upper arm (posterolateral)	
⅝ inch needle	All patients
Intradermal injection is in the deltoid	
Prefilled syringe	All patients

‡A 5/8 inch needle may be used for patients weighing less than 130 lbs (<60kg) for IM injection in the deltoid muscle only if the subcutaneous tissue is not bunched and the injection is made at a 90-degree angle.

I have verified the immunization(s) that the patient requested meets state, age and vaccine restrictions. Initial here: _____

I have verified the requested immunization is the same as the product prepared. Initial here: _____

I have verified the expiration date of the product is greater than today's date. Initial here: _____

For Zostavax®, MMR II®, Varivax®, YF-Vax®, Menveo®, Imovax® and Rabavert®, I have reconstituted the vaccine following the package insert's instructions. Initial here: _____

For patients younger than 9 years of age requesting the influenza vaccine:

Did you verify if a second dose is needed? ☐ Yes ☐ No

If this is the second dose, have 28 days elapsed since the first dose? ☐ Yes ☐ No

Complete AFTER vaccine administration

Vaccine	NDC	Dosage	Site of administration (circle site)	VIS published date
			L/R IM/SQ	

Immunizer name (print): _____ **Immunizer signature:** _____ **Title:** _____

If applicable, intern name (print): _____ **Administration date:** _____ **Date VIS given to patient:** _____

Immunization billing notes section (complete all applicable fields)

Insurance name: _____ **Payer ID/BIN:** _____

Cardholder name: _____ **Recipient ID:** _____ **Group ID:** _____

Notes