



Vaccine Administration Record (VAR) Informed Consent for Vaccination*

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/Provider Name, Physician/Provider Phone, Physician/Provider Address, City, State

SECTION B The following questions will help us determine your eligibility to be vaccinated today. YES NO DON'T KNOW

Table with 19 rows of questions and 3 columns for YES, NO, and DON'T KNOW. Questions cover various vaccine types and patient health conditions.

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 healthcare provider of Walgreens or Take Care Health ServicesSM, as applicable, to administer the vaccine(s) I have requested above.

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

SECTION D (HEALTH CARE PROVIDERS ONLY) Table with columns for Immunizer Name, Signature, RPh/PharmD/RN/LPN/LVN/NP/PA, Vaccine, Lot #, Exp Date, Manufacturer, Dosage, Circle Site of Injection, VIS Date, RPh Pre-fill Initials.

*Healthcare 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.