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

Walgreens healthcare clinic†

PATIENT: COMPLETE SECTIONS A, B, C

SECTION A *(Please print clearly.)*

Store Number: _____ Encounter ID: _____
Store Address: _____

First Name: _____ **Last Name:** _____ **Date of Birth:** _____ **Age:** _____

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

Race/Ethnicity (select one or more)

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

Home Address: _____ **City:** _____ **State:** _____ **ZIP Code:** _____

Email Address: _____ **Medicare Part B Number (if applicable):** _____

Primary Care Physician/Provider Name: _____ **Phone Number:** _____

Address: _____ **City:** _____ **State:** _____ ☐ I do not have a Primary Care Physician/Provider

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 1-14. 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 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) a. If yes, please list: _____	☐ Yes	☐ No	☐ Don't Know
6.	Have you received any vaccinations or skin tests in the past four weeks? a. If yes, please list: _____	☐ Yes	☐ No	☐ Don't Know
7.	Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-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 (Chicken pox, Flu nasal spray, MMR, Oral typhoid, Shingles, Yellow fever) Only answer these questions if you are receiving any immunization listed above				
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
13	Do you have a history of thymus disease (including myasthenia gravis), thymoma or prior thymectomy? (Yellow fever only)	☐ Yes	☐ No	☐ Don't Know
14.	Are you currently taking any antibiotics or antimalarial medications? (Oral typhoid only)	☐ Yes	☐ No	☐ Don't Know
Flu Nasal Spray (FluMist®)				
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: (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 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/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 ("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 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 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 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 or physician's assistant.
†Patient care services at Take Care Clinics are 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.

SECTION D — HEALTHCARE PROVIDER ONLY

Complete BEFORE vaccine administration

Vaccine	Route	Dosage	Lot #	Expiration Date
Influenza (MDV)	Intramuscular	0.5mL		
Influenza (Intradermal)	Intradermal	Prefilled		
Influenza (Nasal)	Intranasal	0.1mL each nostril		
Influenza (High dose)	Intramuscular	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	Subcutaneous	0.5mL		
Meningococcal (Meningitis)	Intramuscular (Subcutaneous – Menomune Only)	0.5mL		
MMR (Measles, Mumps, Rubella)	Subcutaneous	0.5mL		
Pneumococcal (Pneumonia)	Intramuscular	0.5mL		
Polio	Intramuscular	0.5mL		
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			
Typhoid (Inactive injectable)	Intramuscular	0.5mL		
Yellow fever	Subcutaneous	0.5mL		

Needle size	Age
Intramuscular injection is in the deltoid	
⅝ to 1¼ inch needle	3-18 y/o (⅝ inch needle for patients weighing less than 130 lbs)
1 to 1½ inch needle	19 y/o and older (Female 130-200 lbs; Male 130-260 lbs)
1½ inch needle	19 y/o and older (Female 200+ lbs; Male 260+ lbs)
Subcutaneous injection is in the upper arm (postero-lateral)	
⅝ inch needle	All ages
Intradermal injection is in the deltoid	
Prefilled Syringe	All ages

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

I have verified the requested immunization(s) 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®, 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

Rx #	Vaccine	NDC	Dosage	Site of Injection (circle site)	VIS Published Date

Immunizer Name (print): _____ **Immunizer Signature:** _____ **RPh/PharmD/RN/LPN/LVN/NP/PA** (circle one)

If Applicable, Intern Name (print): _____ **Administration Date:** _____ **Date VIS Given to Patient:** _____

Notes