Olden's PHARMACY

Vaccine Administration Record (VAR)

Informed Consent for Vaccination

Which vaccine(s) would you like to receive? **[ ] Flu [ ] Pneumonia [ ] TdaP [ ] Shingrix [ ] Other**

Section A: Patient Information

Last Name	First Name	Date of Birth	Gender
Patient Address	**City**	**State**	**Zip**
Home Telephone	**Mobile**	**E-mail**	

RACE: _____ **ETHNICITY:** _____

Section B: Informed Consent

I certify that I am: (a) the patient and at least **18 years of age**; (b) the legal guardian of the patient; or (c) a person authorized to consent on behalf of the patient where the patient is not otherwise competent or unable to consent for themselves. Further, I hereby give my consent to **Olden's Pharmacy** and the licensed healthcare professional administering the vaccine, as applicable (each an "applicable Provider"), 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 VIS 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 that the patient should remain near the vaccination location for observation for approximately 15 minutes after administration**.** On behalf of the patient, the patient's heirs and personal representatives, I hereby release and hold harmless each applicable Provider, 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 vaccination registry ("State Registry") and my state's health information exchange ("State HIE"); and (b) the applicable Provider may disclose my vaccination information to the State Registry, to the State HIE, or through the State HIE to the State Registry, or to any state or federal governmental agencies or authorities ("Government Agencies"), such as state, county, or local Departments of Health or the federal Department of Health and Human Services, the Center for Disease Control and Prevention, or their respective designees as may be required by law, for purposes of public health reporting, or to my healthcare 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, an opt-out form ("Opt- Out Form") furnished by the applicable Provider: (a) the disclosure of my vaccination information by the applicable Provider to the State HIE and/or State Registry; or (b) the State HIE and/or State Registry from sharing my vaccination information with any of my other healthcare providers enrolled in the State Registry and/or State HIE. The applicable Provider 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 the applicable Provider reporting my vaccination information to the Government Agencies, 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 the applicable Provider 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 the applicable Provider 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 or federal law may permit certain disclosures of my vaccination information to or through the State HIE or to Government Agencies as required or permitted by law. I further authorize the applicable Provider to: (a) release my medical or other information, including any communicable disease (including HIV), and mental health information, to, or through, the State HIE or Government Agencies 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 the applicable Provider with respect to the above requested items and services. I further agree to be fully financially responsible for any cost-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 the applicable Provider invoices me after the time of service, upon receipt of such invoice

Print Name: _____ **Patient/Authorized Person Signature:** _____ **Date:** _____

WHICH ARM WOULD YOU LIKE TO BE VACCINATED? [ ] LEFT ARM [ ] RIGHT ARM

***PLEASE ANSWER SCREENING QUESTIONS ON THE BACK* →**

Section C: Vaccine Administration Information (*for Pharmacy use only*)

Vaccine	NDC	Lot #	Expiration Date	Dosage	Site of Admin	VIS Publish Date

Immunizer (Circle): **PFH WGM JNM USK MF PL JD** Immunizer Signature: _____

Administration Date: _____ Date VIS given to patient: _____

Private and Confidential. Intended for patient or caregiver only. If you have received this document in error, please notify the pharmacy immediately. *Updated: 08/18/2023*

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Section D: Medical Information

The following questions will help us determine your eligibility to be vaccinated today (please ask for assistance if needed):

Do you feel sick today? [ ] Yes [ ] No

1. **Have you been vaccinated in the past 28 days?** [ ] Yes [ ] No

   If yes, please list which vaccines:_____

2. **Do you have any health conditions, such as: Heart Disease, Diabetes, Cancer, or Asthma?** [ ] Yes [ ] No

   If yes, please list (if Cancer, currently on Chemo?):_____

3. **Do you have ALLERGIES to medications, latex, food, or vaccines?** [ ] Yes [ ] No

   Examples: Egg protein, Cow protein, Gelatin, Gentamicin, Polymixin, Neomycin, Phenol, Yeast, or Thiomersol.

   If yes, please list:_____

4. **Have you ever had a serious reaction after receiving an immunization, including fainting or feeling dizzy? Did you require medical assistance?** [ ] Yes [ ] No

5. **Have you ever had a seizure disorder for which you are taking seizure medication(s), a brain disorder, Guillain-Barre Syndrome (a condition that causes paralysis), or other nervous system disorder**? [ ] Yes [ ] No

6. **For women: Are you pregnant, considering to become pregnant in the next month, or breastfeeding?** [ ] Yes [ ] No

7. **Are you on, or have you recently taken medications that affect your immune system?** [ ] Yes [ ] No

   Examples: corticosteroids (Prednisone), anti-rejection medications, chemotherapy?

   If yes, when was your last dose and what was the dose taken?_____

ONLY FILL OUT NEXT SECTION IF YOU DO NOT HAVE PHYSICAL INSURANCE CARD(S)

Section E: Insurance Information (*No need to fill out if BRINGING A COPY of your insurance cards)*

Prescription Insurance:

Are you the primary cardholder □ Yes □ No

If no, relationship to cardholder _____

Prescription Benefit plan name	**Cardholder/Member ID#**	**RxBIN**	**RxGroup #**
		RxPCN	

Medicare Fields:

Do you have Medicare A & B

□ Yes □ No If yes, please provide →

Medicare Number (Refer to Red, White, Blue Card):