



Vaccine Administration Record (VAR)
Informed Consent for COVID-19 Vaccination

Section A: Patient Information

Last Name	First Name	Date of Birth	Gender
Patient Address	City	State	Zip
Home Telephone	Mobile	E-mail	
Primary Care Provider name	PCP Phone Number	PCP Fax Number	
PCP Address	City	State	Zip

Race: _____ Ethnicity: _____

Is this the patient's (First Dose or Second Dose or 3rd/Booster Dose)

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

Prescription Insurance:	Are you the primary cardholder <input type="checkbox"/> Yes <input type="checkbox"/> No If no, relationship to cardholder <input type="checkbox"/> Yes <input type="checkbox"/> No			
Prescription Benefit plan name	Cardholder/Member ID#	RxBIN	RxPCN	RxGroup #
Medicare Fields:				
Do you have Medicare A & B <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare Number (Refer to Red, White, Blue Card):			
If uninsured, you must check the box below to attest that the following information is true and accurate:				
<input type="checkbox"/> I do not have any insurance, including but not limited to Medicare, Medicaid or any other private or government-funded health benefit plan. To have your vaccine administration fee paid for by the United States Health Resources & Services Administration's COVID-19 Program for Uninsured Patients, please provide either (a) a valid Social Security number, (b) state identification number and state of issuance, or (c) a driver's license number and the state of issuance.				
Social Security Number	State Identification Number & State		Driver's License Number & State	

Section C: Medical Information

	YES	NO	DON'T KNOW
1. Are you feeling sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever received a dose of COVID-19 vaccine? <i>If yes, please indicate <input type="checkbox"/> Moderna <input type="checkbox"/> Pfizer <input type="checkbox"/> Janssen (J&J) <input type="checkbox"/> Another product: _____</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had a severe allergic reaction (e.g., anaphylaxis, fainting or dizziness) in the past to ANYTHING? <i>For example, a reaction for which you were treated with epinephrine, or for which you had to go to the hospital?</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was the severe allergic reaction after receiving a COVID-19 vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was the severe allergic reaction after receiving another vaccine or medication?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was the severe allergic reaction related to receiving Polyethylene Glycol or Polysorbate or products containing these?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you been diagnosed w/ multisystem inflammatory syndrome (MIS-C or MIS-A) after a COVID-19 infection?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have a history of <u>myocarditis or pericarditis</u> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you received monoclonal antibodies or convalescent plasma as a COVID-19 treatment in the past 90 days?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have a <u>bleeding disorder</u> or are you taking a <u>blood thinner</u> ? Do you have history or at <u>risk for clots</u> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever had a seizure disorder for which you are taking seizure medication(s), a brain disorder, Guillain-Barre' Syndrome or other nervous system disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Are you moderately/severely immunocompromised (ie: HIV, cancer treatment), a transplant patient, or taking immunosuppressing medication (ex: anti-rejection medications, medications for RA, high-dose steroids)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. For women: Are you currently pregnant or breast feeding?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you received dermal fillers? If yes, where on your body? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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Section D: 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 or EUA Fact Sheet 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 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:** _____

Section E: COVID-19 Vaccine Administration Information (for Pharmacy use only)

Administration Date	Time In	Time Out	EUS/VIS Date	Manufacturer	Volume (mL)
				<input type="checkbox"/> Moderna <input type="checkbox"/> Pfizer <input type="checkbox"/> Janssen J&J <input type="checkbox"/> Another product:	<input type="checkbox"/> 0.5 <input type="checkbox"/> 0.3 <input type="checkbox"/> other
Lot #	Exp. Date	Route	Site	Patient Temperature (°F)	
		IM	<input type="checkbox"/> L <input type="checkbox"/> R Deltoid		

Administering Immunizer Name & Title: _____ **Administering Immunizer Signature:** _____