## VAR - Vaccine Administration Record

Name:				Bir	th date:		Age:	Se	x: M /	F
Address	s:			Cit	y:			State:	Zip	:
Phone:		Emergen	cy Contact N	ame & Phone: _				_		
Medica	re ID# (including alph	a):	Ir	surance			Member ID			
Group #	#		Bin #	PCN#						
	Please check off th eceiving today:	e vaccine(s) you		Influenza (Flu COVID-19		ningles eumococo		] Td/Tdap ] Other		
Screen	ning Checklist: Th	he following ques	stions will h	elp us deterr	nine your el	gibility to	be vaccina	ted today.		
I. Do	you feel sick toda	ay?						🗌 Yes	🗌 No	🗌 Don't
2. Hav	ve you been diag	nosed with or te	sted positiv	ve for COVIE	0-19 in the l	ast 21 da	ys?	Yes	🗌 No	🗌 Don't
(exa poly	you have a histor amples: polyethyl ymyxin, neomycin es, please list:	ene glycol, polys n, phenol, yeast o	sorbate, eg or thimeros	igs, bovine p al)?				i 🗌 Yes	□ No	🗌 Don't
4. Haγ	ve you ever had a	a reaction after re	eceiving a	vaccination,	including fa	inting or	feeling dizz	y? 🗌 Yes	🗌 No	🗌 Don't
	ve you ever had a order, Guillain-Ba							_		🗌 Don't
3. Hav	ve you received a	ny vaccinations	or skin tes	ts in the pas	t four weeks	s? If yes,	please list:	Yes	🗆 No	🗌 Don't
imn	you have any chr nunocompromise es, please list:	d, chronic lung d	lisease, ob	esity, sickle	cell disease	ey diseas , diabete	e, s, heart dis	Yes ease?	□ No	🗆 Don't
3. For	women: Are you	pregnant or con	sidering b	ecoming pre	gnant in the	next mo	nth?	🗌 Yes	🗌 No	🗌 Don't
	Do you have a bleeding disorder or are you taking a blood thinner? Do you have a condition that may weaken your immune system (e.g., cancer, leukemia,							🗌 Yes	🗌 No	🗌 Don't
	you have a condi phoma, HIV/AIDS		eaken your	immune sys	stem (e.g., c	ancer, le	ukemia,	Yes	🗌 No	🗌 Don't
Enb	you currently on brel®, high-dose r gs or radiation tre	methotrexate, az						☐ Yes	🗌 No	🗌 Don't
	you currently taki longer than 2 we		eroid thera	py (predniso	ne > 20mg/	day or eq	uivalent)	☐ Yes	🗌 No	🗌 Don't
	or COVID-19 vac ecifically for CO							☐ Yes	🗌 No	🗌 Don't
	<b>r COVID-19 vaco</b> s, please list whic				se of any CO	OVID-19	/accine? If	Yes	□ No	🗌 Don't
mi ar Di ur Vo Fe	onsent: Most comm uscle aches. Sympt nd I take full respon ontraindications liste aly Drug to release nder Medicare, Med oluntarily disclose he ederal registries for have read, or had eccive and underst	oms usually last 24 nsibility to seek m ad in the "Screenir information and re- icaid, or the HRSA ealth information to purposes of treatm <b>explained to me,</b>	4-48 hours. edical atten ng Checklist equest payn COVID-19 my Priman nent, payme <b>the 2021-2</b>	I release Daly tion should m " that would p nent. I certify t Program for L / Care Physici ent, or health c D22 Vaccine I	Drug from re- nore severe so prevent me fr he informatio Jninsured Pat an, my insura are operation	sponsibilit symptoms om receiv n given is ients. I uno ance plan, is.	y of any read occur. I acl ing a vaccin correct and derstand Da health syste	ction resulting knowledge I lation at this accurate in a ly Drug may I ms and hospi	from the have not time. I oplying be requi- tals, an	o authorize for paymen ired to or m d State or
nature	of Patient or Legal Gu	lardian		Relation	to Patient (if n	ot patient)		- [	Date	
gnature	of Patient or Legal Gu	Jardian		Relation		. ,		Ē	)ate	