Vaccine Administration Record (VAR)—Informed Consent for Vaccination

Store number: _____ Rx number: _____
Store address: _____

Laurel PHARMACY

SECTION A

Please print clearly.

First name: _____ **Last name:** _____

Date of birth: _____ **Age:** _____ **Gender:** ☐ Female ☐ Male **Phone:** _____

☐ **I wish to receive text message alerts regarding my prescriptions.**

Home address: _____ **City:** _____

State: _____ **ZIP code:** _____ **Email address:** _____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American ☐ White
☐ Other Race _____ ☐ Unknown

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ethnicity

Laurel Pharmacy will send vaccination information from this visit to your doctor/primary care provider using the contact information provided below.

Doctor/primary care provider name: _____ **Phone:** _____

Address: _____ **City:** _____ **State:** _____ **ZIP code:** _____

I want to receive the following vaccination(s): _____

SECTION B

The following questions will help us determine your eligibility to be vaccinated today.

All vaccines

1.	Do you feel sick today?	☐ Yes	☐ No	☐ Don't know
2.	Have you been diagnosed with or tested positive for COVID-19 in the last 14 days?	☐ Yes	☐ No	☐ Don't know
3.	In the past 14 days have you been identified as a close contact to someone with COVID-19?	☐ Yes	☐ No	☐ Don't know
4.	Do you have a history of allergic reaction or allergies to latex, medications, food or vaccines (examples: polyethylene glycol, polysorbate, eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal)? If yes, please list: _____	☐ Yes	☐ No	☐ Don't know
5.	Have you ever had a reaction after receiving a vaccination, including fainting or feeling dizzy?	☐ Yes	☐ No	☐ Don't know
6.	Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-Barré syndrome (a condition that causes paralysis) or other nervous system problem?	☐ Yes	☐ No	☐ Don't know
7.	Have you received any vaccinations or skin tests in the past eight weeks? If yes, please list: _____	☐ Yes	☐ No	☐ Don't know
8.	Have you ever received the following vaccinations? ☐ Pneumonia: Date received _____ ☐ Shingles: Date received _____ ☐ Whooping cough: Date received _____			
9.	Do you have any chronic health conditions such as cancer, chronic kidney disease, immunocompromised, chronic lung disease, obesity, sickle cell disease, diabetes, asthma or heart disease? If yes, please list: _____	☐ Yes	☐ No	☐ Don't know
10.	**For women:** Are you pregnant or considering becoming pregnant in the next month?	☐ Yes	☐ No	☐ Don't know
11.	**For COVID-19 vaccine only:** Have you been treated with antibody therapy specifically for COVID-19 (monoclonal antibodies or convalescent plasma)?	☐ Yes	☐ No	☐ Don't know

For chickenpox, MMR® II, shingles, Vaxchora®, yellow fever only:
Answer the following questions only if you are receiving any vaccinations listed above.

12.	Do you have a condition that may weaken your immune system (e.g., cancer, leukemia, lymphoma, HIV/AIDS, transplant)?	☐ Yes	☐ No	☐ Don't know
13.	Are you currently on home infusions, weekly injections such as Humira® (adalimumab), Remicade® (infliximab) or Enbrel® (etanercept), high-dose methotrexate, azathioprine or 6-mercaptopurine, antivirals, anticancer drugs or radiation treatments?	☐ Yes	☐ No	☐ Don't know
14.	Are you currently taking high-dose steroid therapy (prednisone > 20mg/day or equivalent) for longer than 2 weeks?	☐ Yes	☐ No	☐ Don't know
15.	Have you received a transfusion of blood or blood products or been given a medication called immune (gamma) globulin in the past year?	☐ Yes	☐ No	☐ Don't know
16.	Do you have a history of thymus disease (including myasthenia gravis, DiGeorge syndrome or thymoma), or had your thymus removed? (yellow fever only)	☐ Yes	☐ No	☐ Don't know
17.	Do you have a history of thrombocytopenia or thrombocytopenic purpura? (MMR only)	☐ Yes	☐ No	☐ Don't know
18.	Have you consumed any food or drink in the last hour? (Vaxchora® only)	☐ Yes	☐ No	☐ Don't know
19.	Have you taken antibiotics in the last 14 days or antimalarials in the last 10 days? (Vaxchora® only)	☐ Yes	☐ No	☐ Don't know

SECTION C

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 Laurel 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) I have received, read and/or had explained to me the 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 in the vaccination area for 15 minutes after administration and for 30 minutes after administration of higher severity allergenic pharmacy administration. I also understand that the applicable Provider has documentable proof, including my permission to access information regarding vaccination information by law. I understand that I am permitting my release to my doctor/primary care provider by law, I understand(s), and third parties as necessary, including but not limited to my current immunization records and other information about me, my vaccination abortainment with vaccintand that I treatment. I undected to facilitate timeliness. I understand that my insurance information is collected to facilitate internet administrative process, I ad administration por the applicab(s) I received today. I authorize Laurelhurst Pharmacy and the applicable Provider to come through email, text or telephone at contact information provided herein may apply. For text reading vaccination reminders, the applicable Provider's and data rates may apply. For text HELP and/or STOP for help; the applicable Provider can opt out from receiving such messages at any time. Laurelhurst the applicable, and applicable. Have my my permission to share the results healthcare services, including insurance companies, attorneys, employers and others as provided by the Internet based healthcare services. Hold harmless for interruptions, providers. I consenting the named pentand Provider will receive a receive a fee for items dispensed in connection with this visit. Neither Provider nor Provider with with this visit. I hereby consent to Provider and applicable Provider to my the to immunization records (including my vaccination the latest information) to the extent required by law. I understand that the case provided) to the extent. I understand that the vaccine related information to be sent to Indiana by understand that the vaccination I received today may be provided through forms through the applicable Provider, (i) the purchase and administration services by Laurel Pharmacy or (ii) the State Immunization Information System or other designated immunization registry(ies), if applicable.

Patient signature: _____ **Date:** _____
(Parent or guardian, if minor)

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