COVID-19 Vaccine Administration Record **MODERNA BOOSTER DOSE ONLY**

HOAGLAND PHARMACY
Your health matters.

First Name: _____ Last Name: _____ Date of Birth: _____ Gender: M F Phone: _____

Address: _____ City: _____ State:_____ ZIP Code: _____ Email Address: _____

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 Hoagland Pharmacy and the licensed healthcare professional administering the vaccine, as applicable (each an "applicable Provider"), to administer the COVID-19 vaccine I have requested. I understand that it is not possible to predict all possible side effects or complications associated with receiving the vaccine. I understand the risks and benefits associated with the COVID-19 and have received, read and/or had explained to me the EUA Fact Sheet on the COVID-19 vaccine. 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 all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the COVID-19 vaccine.

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. Hoagland Pharmacy may disclose your vaccination information from this visit for public health purposes. Hoagland Pharmacy will send your vaccine information to your employer as required. I certify that I have sufficient knowledge of the patient's condition to answer the Screening Questions.

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

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

1.	Do you feel sick today?	Yes	No	Don't Know
2.	Do you have any health conditions, such as heart disease, diabetes or asthma? If yes, please list: _____	Yes	No	Don't Know
3.	Do you have allergies to medications, food or vaccines? If yes, please list: _____	Yes	No	Don't Know
4.	Have you ever had a reaction after receiving a vaccination, including fainting or feeling dizzy?	Yes	No	Don't Know
5.	Have you ever had medications for a seizure, brain, immune or nervous system disorders?	Yes	No	Don't Know
6.	**For women:** Are you pregnant or considering becoming pregnant in the next month?	Yes	No	Don't Know

HEALTHCARE PROVIDER ONLY

Complete BEFORE vaccine administration

1.	I have reviewed the Patient Information and Screening Questions.	Initials: _____
2.	I have verified that this is the vaccine requested by the patient.	Initials: _____
3.	The vaccine is appropriate for this patient based on the Age Guidelines and other Guidelines provided by federal and state regulations.	Initials: _____
4.	Does this patient have a high-risk medical condition? If yes, please list: _____	Yes No
5.	The Vaccine NDC matches the NDC on the bottom of this VAR form and the NDC on the patient leaflet. (Perform 3-way NDC match.)	Initials: _____
6.	I have verified the Expiration Date is greater than today's date and have entered the Lot # and Expiration Date in the field below.	Initials: _____

Complete DURING the patient interaction

1.	I confirm(ed) the patient's **Name, DOB and Requested Vaccine** and verified it matches the information on the VAR form.	Initials: _____
2.	I have reviewed the **Screening Questions** and answers.	Initials: _____
3.	I provided a **EUA Fact Sheet** to the patient or the representative.	Initials: _____

Complete AFTER vaccine administration

Vaccine	NDC	Manufacturer	Dosage		Site of administration	EUA Fact Sheet published date
COVID-19	80777-0282-99	Moderna Bivalent	0.5ml	Booster #1 Booster #2	LD RD	04/18/2023

Clinician's name (print): _____ Clinician's signature: _____ Title: _____

Administration date: _____ Date Fact Sheet given to patient: _____

COVID-19 VACCINE LOT# _____ **COVID-19 VACCINE EXPIRATION DATE:** _____