Vaccine Administration Record (VAR)

Informed Consent for Vaccination

Section A

First Name_____ Last Name _____Date of Birth_____
Home Address_____ City _____State_____ Zip_____
Phone Number_____ Primary Care Physician _____Physician Phone _____
E-mail address _____

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

For all Vaccines: Please answer questions 1-9. For Live Vaccines (Zostavax), Please answer questions 1-14.

		Yes	No	Don't Know
All Vaccines	1. Are you currently sick with a moderate to high fever, vomiting/diarrhea?			
	2. Do you have allergies to medications, food or vaccines? (Eggs, Bovine protein, Gelatin, Gentamicin, Polymyxin, Neomycin, Phenol or Thimerosal. If yes, please list.			
	3. Have you received any vaccinations in the past 4 weeks? If yes, please list.			
	4. Have you ever had a serious reaction to an influenza vaccine or any vaccine in the past?			
	5. Have you ever had a seizure disorder for which you are on seizure medications, a brain disorder, Guillain-Barre Syndrome (a condition that causes paralysis) or other nervous system problems?			
	6. Do you have an immunocompromising condition (cancer, leukemia, lymphoma, HIV?AIDS, transplant) functional or anatomic asplenia, CSF leak or cochlear implant?			
	7. Are you 65 years of age or older?			
	8. Do you smoke or have chronic conditions (diabetes, heart disease, asthma)?			
	9. For women - Are you pregnant or considering becoming pregnant?			
Live Vaccines	10. Do you have cancer, leukemia, lymphoma, HIV/AIDS, or any other immune system disorder or are in contact with anyone who has a severely weakened immune system?			
	11. Are you currently on home infusions, weekly injections, high dose methotrexate, azathioprine or 6-mercaptopurine, antiviral, anticancer or radiation treatment/			
	12. Have you received a transfusion of blood or blood products, or been give a medicine called Immune globulin in the past year?			
	13. Are you currently taking high-dose steroid therapy (prednisone >20mg/day or equivalent) for more than 2 wks?			
	14. Do you have a history of thrombocytopenia or thrombocytopenic purpura? (MMR only)			

Section C: I certify that I am (1) the patient and at least 18 years of age (2) the parent or legal guardian of the minor patient or (3) the legal guardian of the patient. Further, I herby give my consent to the health care provider of Michelle's Pharmacy, Inc. 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 Vaccine Information Statements on the vaccine(s) I have elected to receive. I also acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation by the administering health care provider. On behalf of myself, my heirs, and personal representatives, I hereby release and hold employees from any and all liabilities or claims whether know or unknown arising our tof, in connection with or in any way related to the administration of the vaccine(s) listed above. I authorize Michelle's Pharmacy, Inc. to release any medical or other information to my health care professionals, Medicare, Medicaid, or other third party payor necessary of effectuate care or payment and request that payment of authorized benefits be made on my behalf to Michelle's Pharmacy, Inc. with respect to the vaccine(s) listed above.

Signature _____Date_____

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Section D: (Healthcare Providers only)

Immunizer Name _____Immunizer Signature _____

Vaccine	Lot#	Exp Date	Manufacturer	Dosage	Circle Site of Injection	VIS Date	Date PNL sent
Inactivated Influenza					R L IM Deltoid		
Pneumococcal Poly saccharide					R L IM Deltoid		
					R L IM Deltoid		