



Vaccine Administration Record (VAR) Informed Consent for Vaccination for all Healthcare Providers

Section A *Please print clearly and complete both sides*

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ Age: _____ Sex: Male Female Other

Home Address: _____

Phone Number: _____ Email Address: _____

Primary Care Physician: _____ Physician Phone: _____

Physician Address: _____

Prescription Insurance: Is the patient the primary cardholder? Yes No If No, primary cardholder's date of birth: _____

Prescription Plan Name	Cardholder ID	Rx Group ID	BIN	PCN
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Medical Insurance: Is the patient the primary cardholder? Yes No If No, include primary cardholder's date of birth: _____

Medical Plan Name	Cardholder ID	Group ID	Payer ID
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Medicare Fields: Is the patient aged 65 years and older or Medicare eligible? Yes No

Medicare Part A/B ID Number (MBI)

Section B *The following questions will help determine your vaccine eligibility*

For ALL vaccines, answer questions 1-8	Yes	No	Unsure
1. Which vaccines are you requesting today? Please list all requested vaccines:			
2. Are you currently sick? Are you experiencing any fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches?			
3. Do you have any allergies to medications, food, or vaccines? (Example: eggs, protein, gelatin, gentamicin, neomycin, polymixin, phenol, or thimerosal) Please list all:			
4. Have you received any vaccines in the past 4 weeks? If so, please list all:			
5. Have you ever had a serious or severe allergic reaction (anaphylaxis, difficulty breathing, swelling of throat, tongue or face) to any vaccine or injectable therapy, or a history of anaphylaxis due to any cause?			
6. Have you ever had a seizure disorder for which are on seizure medication(s), a brain disorder, Guillian-Barre Syndrome (a condition that causes paralysis) or other serious nervous problems?			
7. Are you on immunosuppressive therapy such as long term steroids, cancer chemotherapy, radiation therapy, monoclonal antibodies, etc?			
8. For women: Are you or considering becoming pregnant in the next month?			
For COVID-19 vaccines, answer questions 9-14	Yes	No	Unsure
9. Have you tested positive for COVID-19 in the past 3 months?			
10. Are you currently in quarantine for COVID-19 exposure?			
11. Have you received a COVID-19 vaccine within the past 6 months?			
12. Are you considered moderately or severely immunocompromised? Examples include active cancer treatment, organ transplant, stem cell transplant, advanced or untreated HIV, high dose steroids or other medications that suppress your immune system, etc.			
13. Do you have a bleeding disorder or are you taking blood thinners such as aspirin, warfarin, Eliquis, Xarelto?			
14. Have you received convalescent plasma or monoclonal/polyclonal antibody infusions for COVID-19 within the past 3 months?			
For PNEUMOCOCCAL vaccines, answer questions 15-16	Yes	No	Unsure
15. Have you ever received a pneumococcal vaccine (such as Pneumovax or Prevnar) in the past?			
16. Do you have a chronic health or immunocompromising condition such as diabetes, chronic liver disease, HIV/AIDS, sickle cell disease, taking immunosuppressive drugs or radiation therapy, etc?			

For RSV vaccines, answer questions 17-19	Yes	No	Unsure
17. Are you 75 years or older?			
18. Are you at risk for severe RSV? Risk factors include chronic heart disease, chronic lung disease, end stage kidney disease or being on hemodialysis, complicated diabetes, chronic liver disease, chronic blood conditions, severe obesity (BMI >40), residence in nursing home, severely weakened immune system, etc.			
19. Have you ever received an RSV vaccine (such as Arexvy or mRESVIA) in the past?			
For LIVE vaccines, answer the following questions 20-22	Yes	No	Unsure
20. Do you have cancer, leukemia, lymphoma, HIV/AIDS, or any other immune disorder or are in contact with anyone who has a severely weakened immune system?			
21. Are you currently on home infusions, weekly infusions, injections such as Remicade, Enbrel, Humira, Kineret, high dose steroids, chemotherapy, radiation therapy, etc?			
22. Have you received a transfusion of blood, blood products or immune (gamma) globulin in the past year?			

Section C

I certify that I am the patient and at least 18 years of age. I hereby give my consent to the healthcare providers of Bell Healthcare Enterprises, as applicable, 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 those vaccine(s). I understand the risk 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 had a chance to ask questions and that such questions were answered to my satisfaction. Further, I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation by healthcare provider. On behalf of myself, my heirs, and personal representatives, I hereby release and hold harmless Bell Healthcare Enterprises, as applicable, staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors, and employees from any and all liabilities or claims whether known arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above. I authorize Bell Healthcare Enterprises, as applicable, to release any medical or other information to my health care professionals, Medicare, Medicaid, or any other third party necessary to effectuate care or payment of authorized benefits be made on my behalf to Bell Healthcare Enterprises, as applicable, with respects to the vaccine(s) listed above.

Patient/Guardian Signature: _____ Date: _____

Relationship to Patient (if other than patient): _____

Section D *The following section below is to be completed by the health care provider only*

Immunizer Name: _____ Signature: _____ RPh/PharmD VIS Date: _____

Brand	Vaccine	Manufacturer	Lot #	Exp. Date	Dose	Needle	Injection Site
Abrysvo	RSV	Pfizer			0.5 ml	25G / 5/8" 1" 1½	L / R Deltoid IM
Adacel	Tdap	Sanofi			0.5 ml	25G / 5/8" 1" 1½	L / R Deltoid IM
Afluria	Influenza	Seqirus			0.5 ml	25G / 5/8" 1" 1½	L / R Deltoid IM
Arexvy	RSV	GSK			0.5 ml	25G / 5/8" 1" 1½	L / R Deltoid IM
Bexsero	Meningococcal B	GSK			0.5 ml	25G / 5/8" 1" 1½	L / R Deltoid IM
Boostrix	Tdap	GSK			0.5 ml	25G / 5/8" 1" 1½	L / R Deltoid IM
Capvaxive	Pneumococcal	Merck			0.5 ml	25G / 5/8" 1" 1½	L / R Deltoid IM
Comirnaty	COVID-19	Pfizer			0.3 ml	25G / 5/8" 1" 1½	L / R Deltoid IM
Engerix-B	Hepatitis B	GSK			0.5 ml 1 ml	25G / 5/8" 1" 1½	L / R Deltoid IM
Flucelvax	Influenza	Seqirus			0.5 ml	25G / 5/8" 1" 1½	L / R Deltoid IM
Fluad	Influenza	Seqirus			0.5 ml	25G / 5/8" 1" 1½	L / R Deltoid IM
Havrix	Hepatitis A	GSK			0.5 ml 1 ml	25G / 5/8" 1" 1½	L / R Deltoid IM
Menveo	Meningococcal	GSK			0.5 ml	25G / 5/8" 1" 1½	L / R Deltoid IM
MMRII	MMR	Merck			0.5 ml	25G / 5/8" 1" 1½	L / R Deltoid IM
mRESVIA	RSV	Moderna			0.5 ml	25G / 5/8" 1" 1½	L / R Deltoid IM
Pneumovax	Pneumococcal	Merck			0.5 ml	25G / 5/8" 1" 1½	L / R Deltoid IM
Pevnar 20	Pneumococcal	Pfizer			0.5 ml	25G / 5/8" 1" 1½	L / R Deltoid IM
Shingrix	Shingles	GSK			0.5 ml	25G / 5/8" 1" 1½	L / R Deltoid IM
Spikevax	COVID-19	Moderna			0.5 ml	25G / 5/8" 1" 1½	L / R Deltoid IM
Trumenba	Meningococcal B	Pfizer			0.5 ml	25G / 5/8" 1" 1½	L / R Deltoid IM
Varivax	Varicella	Merck			0.5 ml	25G / 5/8" 1" 1½	L / R Tricep SQ