Vaccine Administration Record (VAR)—Informed Consent for Vaccination

Rx #_____

715-567-5700 715-298-0494(f)

Wausau Family Pharmacy
630 S. 3rd Ave
Wausau, WI 54401

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

Wausau Family 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 condition such as cancer, chronic kidney disease, immunocompromised, chronic lung disease, obesity, sickle cell disease, diabetes, 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 Wausau Family Pharmacy 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) and 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 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 any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above. 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 Centers 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. Wausau Family Pharmacy or its affiliates may contact you, including by autodialed and prerecorded calls and texts, at any time, using the contact information provided in your patient record regarding health and safety matters, such as vaccine reminders.

Patient signature: _____ **Date:** _____

(Parent or guardian, if minor)

SECTION D — INSURANCE–PATIENT OR AUTHORIZED PERSON TO COMPLETE

Please ensure to record BOTH pharmacy AND medical insurance information since there are multiple ways vaccinations can be billed at Wausau Family Pharmacy.

	Pharmacy card	Medical card
Insurance Plan/Plan ID:		
Member/Recipient ID #:		
RX BIN:		N/A
RX PCN:		N/A
Group Number:		

Medicare	Medicare Part B
Medicare number:*	
Last 4 digits of SSN:†	

*Number on the red, white and blue Medicare card.
†For insurance confirmation purposes only.

Are you the cardholder? ☐ Yes ☐ No
If no, please provide cardholder's name, date of birth (MM/DD/YYY) and relationship:
_____

COVID-19 VACCINATION ONLY

If uninsured: I attest that I do not have any medical or pharmacy insurance. ☐ Yes

Drivers license/State ID number* (circle one) _____ Issuing state: _____
*For verification and coverage Initial here: _____

Healthcare provider only: Individual refused to provide insurance information when I attempted to obtain the insurance information from the individual. ☐ Yes

SECTION E — HEALTHCARE PROVIDER ONLY

Complete BEFORE vaccine administration

1. I have reviewed the **Patient Information and Screening Questions.** Initial here: _____
2. I have verified that this is the **vaccine requested** by the patient. Initial here: _____
3. This vaccine is appropriate for this patient based on the **Age Guidelines** provided by federal and/or state regulations and company policies. Initial here: _____
   3a. Does this patient have a high-risk medical condition? ☐ Yes ☐ No
   If yes, please list medical condition(s): _____
4. I have discussed with the patient additional immunizations the patient may be eligible for based on age and/or health conditions Initial here: _____
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**.) Initial here: _____
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. Initial here: _____
7. I have made every attempt to obtain and confirm patient insurance information Initial here: _____

For COVID-19, Shingrix®, MMR® II, Varivax®, YF-Vax®, Menveo®, Imovax®, Vaxchora® and RabAvert®, ensure the vaccine is reconstituted following the package insert's instructions.

SECTION F

Complete DURING the patient interaction

1. I have asked the patient to confirm their **Name, DOB and Requested Vaccine** and verified it matches the information on the VAR form. Initial here: _____
2. I have reviewed the **Screening Questions** with the patient. Initial here: _____
3. I have reviewed the **VIS/Patient Fact Sheet** with the patient. Initial here: _____

SECTION G

Complete AFTER vaccine administration

Vaccine	NDC	Manufacturer	Dosage	Dose # (if applicable)	Site of Administration	Vaccine Lot #	Vaccine Expiration	Diluent Lot # (if applicable)	Diluent Expiration (if applicable)	VIS/Patient Fact Sheet Published Date

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

If applicable, intern/tech name (print): _____ **Administration date:** _____

Date EUA Fact Sheet/VIS given to patient: _____

Notes

Reminder

1. Update the patient's record with any new allergy, health condition or primary care provider information.
2. Enter vaccine lot #, expiration date and site of administration, then scan the VAR form into the patient's record.