3058 Campbellsville Rd. 270.380.1230

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

First Name: ____________________ **Last Name:** ____________________ **Date of Birth:** ____________

Gender: ☐Female ☐Male **Phone:** ________________ **Allergies:** ______________________________

Home Address: ____

City: ________________________ **State:** ______ **ZIP:** __________ **SSN:** ________________

I want to receive the following vaccination(s):

☐Flu (influenza) ☐Other: ____

Please ask if you have questions about your eligibility for vaccinations other than influenza.

SCREENING CHECKLIST FOR CONTRAINDICATIONS

The following questions will help us determine your eligibility to be vaccinated today. If you answer "Yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions may be asked. If a question is not clear, please ask for further explanation.

1. Are you currently sick with a moderate to high fever, vomiting/diarrhea? ☐Yes ☐No ☐Don't know
2. Have you ever fainted or felt dizzy after receiving an immunization? ☐Yes ☐No ☐Don't know
3. Have you ever had a reaction after receiving an immunization? ☐Yes ☐No ☐Don't know
4. Do you have an immunocompromising condition (e.g., cancer, leukemia, lymphoma, HIV/AIDS, transplant), functional or anatomic asplenia, CSF leak or cochlear implant? ☐Yes ☐No ☐Don't know
5. Have you ever had a seizure disorder for which you are on seizure medications, a brain disorder, Guillain-Barré syndrome or other nervous system problems? ☐Yes ☐No ☐Don't know
6. **For women:** Are you pregnant or considering becoming pregnant in the next month? ☐Yes ☐No ☐Don't know

I certify that I am: (a) the patient and at least 18 years of age; (b) the parent or legal guardian of the minor patient; or (c) the legal guardian of the patient. Further, I hereby give my consent to the healthcare provider of North Century Pharmacy, as applicable, to administer the vaccine(s) I have requested. 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 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 the administering healthcare provider. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless North Century Pharmacy, as applicable, 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). I further authorize North Century Pharmacy, as applicable, to (a) release my medical or other information, including my communicable disease (including HIV), mental health and drug/alcohol abuse information, to, or through, the State HIE 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 North Century Pharmacy as applicable, with respect to the above requested items and services. **I further agree to be fully financially responsible for any cosharing 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 North Century Pharmacy invoices me after the time of service, upon receipt of such invoice.**

Signature: ____ **Date:** ____________

(Parent or guardian, if minor)

HEALTHCARE PROVIDER ONLY

Vaccine	NDC	Lot #	Exp. Date	Dosage	Site of Admin.	Date on VIS	VIS Given Date
					LA/RA IM/SQ		
					LA/RA IM/SQ		
					LA/RA IM/SQ		

Vaccinator (signature or initials and title): ______________________________ **Administration Date:** ______________