Community Off-Site Vaccine Administration Record (VAR)
Informed Consent for Vaccination*

Walgreens

If the patient is requesting a flu vaccination, indicate the patient's age group:	OFF-SITE CLINIC BILLING GROUP:	Store number: 7978 Store address: 1395 W D ST, NORTH WILKESBORO, NC 28659 Rx number: _____
☐ Under 65 years of age (Fluvirin, Flucelvax and Fluarix) ☐ Age 65 or older (Fluad, Fluzone HD or any of the above)		

SECTION A *(Please print clearly.)*

First name: _____ **Last name:** _____

Date of birth: _____ **Age:** _____ **Gender:** ☐ Female ☐ Male **Phone:** _____

Home address: _____ **City:** _____

State: _____ **ZIP code:** _____ **Email address:** _____

Walgreens 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 number:** _____

Address: _____ **City:** _____ **State:** _____

I want to receive the following vaccination: _____

SECTION B *The following questions will help us determine your eligibility to be vaccinated today.*

All vaccines

1.	Are you sick today?	☐ Yes	☐ No	☐ Don't know
2.	Do you have allergies to medications, food, yeast, a vaccine component or latex?	☐ Yes	☐ No	☐ Don't know
3.	Have you ever had a serious reaction after receiving a vaccination?	☐ Yes	☐ No	☐ Don't know
4.	Has any physician or other healthcare professional ever cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a medical setting?	☐ Yes	☐ No	☐ Don't know
5.	Do you have a long-term health problem, such as heart disease, lung disease, liver disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia or other blood disorder? (If so, these need to be addressed in protocol based on current accepted guidelines.)	☐ Yes	☐ No	☐ Don't know
6.	Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem? Have you been diagnosed with rheumatoid arthritis, ankylosing spondylitis or Crohn's disease?	☐ Yes	☐ No	☐ Don't know
7.	In the past three months, have you taken medications that weaken your immune system, such as cortisone, prednisone, other steroids or anticancer drugs, or have you had radiation treatments?	☐ Yes	☐ No	☐ Don't know
8.	Have you had a seizure, a brain disorder, Guillain-Barré syndrome or other nervous system problem?	☐ Yes	☐ No	☐ Don't know
9.	During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? (Response needs to be addressed in protocol.)	☐ Yes	☐ No	☐ Don't know
10.	Have you received any vaccinations or a TB skin test in the past four weeks?	☐ Yes	☐ No	☐ Don't know
11.	Do you have a history of fainting, particularly with vaccines? (If so, need vagal precautions built into protocol with triage and treatment recommendations should this occur at pharmacy.)	☐ Yes	☐ No	☐ Don't know
12.	For Tdap and adult Td: Do you have a cut, injury, puncture or open wound that prompted you to get a tetanus shot?	☐ Yes	☐ No	☐ Don't know
13.	For zoster—add the following: a. Have you had a past reaction to gelatin or triple antibiotic ointment?	☐ Yes	☐ No	☐ Don't know
14.	**For women:** Are you pregnant or is there a chance you could become pregnant during the next month?	☐ Yes	☐ No	☐ Don't know

*Healthcare providers can be a vaccination-certified pharmacist or a registered nurse, licensed practical nurse, licensed vocational nurse, nurse practitioner, physician or physicians assistant.

Patient care services at Walgreens Healthcare Clinic provided by Take Care Health Services, an independently owned professional corporation whose licensed healthcare professionals are not employed by or agents of Walgreen Co. or its subsidiaries, including Take Care Health Systems, LLC.

Patient name: _____

SECTION C

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 Walgreens, Duane Reade, Take Care Health Services or DR Walk-in Medical Care, 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 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 the 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, 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 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 may permit certain disclosures of my vaccination information to or through the State HIE as required or permitted by law. I also authorize the applicable Provider to disclose my, or my child's (or unemancipated minor for whom I am authorized to act as guardian or in loco parentis), proof of vaccination to the school where I am, or my child (or unemancipated minor for whom I am authorized to act as guardian or in loco parentis) is, a student or prospective student. I further authorize the applicable Provider 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 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.

Patient signature: _____ **Date:** _____
(Parent or guardian, if minor)

SECTION D — HEALTHCARE PROVIDER ONLY

Complete <u>BEFORE</u> vaccine administration

1. I have reviewed the **Patient Information** and **Screening Questions.** Initial here: _____
2. 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. 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: _____
5. 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: _____

Lot #: _____ Expiration Date: _____

Note: For Zostavax®, MMR® II, Varivax®, YF-Vax®, Menveo®, Imovax® and Rabavert®, ensure the vaccine is reconstituted following the package insert's instructions.

SECTION E

Complete <u>DURING</u> 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** with the patient. Initial here: _____

SECTION F

Complete <u>AFTER</u> vaccine administration

Vaccine	NDC	Manufacturer	Dosage	Site of administration	VIS published date

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

If applicable, intern name (print): _____ **Administration date:** _____ **Date 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.