Walgreens

JHED ID: _____
Job Title: _____

Vaccine Administration Record (VAR) — Informed Consent for Vaccination

Store number: _____ **Rx number:** _____ ☐ **Off-site** ☐ **In store**

SECTION A

Patient name: _____ **Date of birth:** _____ **Age:** _____ **Gender assigned at birth:** _____

Phone number: _____ ☐ **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 ☐ Prefer not to answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Walgreens will send immunization information from this visit to your doctor/primary care provider using the contact information provided below.

Primary care physician/provider name: _____ **Phone number:** _____

Address: _____ **City:** _____ **State:** _____ **ZIP code:** _____

I want to receive the following vaccination(s): Vaccine 1 INFLUENZA _____ Vaccine 2 _____

Vaccine 3 _____ Vaccine 4 _____

Is the information in Section A above correct? ☐ **Yes** ☐ **No (If no, please alert the pharmacy staff.)**

SECTION B

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

All Vaccines

1.	Have you felt sick within the last 24 hours?	☐ Yes	☐ No	☐ Don't know
2.	Do you have a history of allergic reaction or allergies to latex, medications, food or vaccines (examples: polyethylene glycol, polysorbate, eggs, bovine protein, gelatin, ciprofloxacin, gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal)? If yes, please list: _____	☐ Yes	☐ No	☐ Don't know
3.	Have you ever had a reaction after receiving a vaccination, including fainting or feeling dizzy?	☐ Yes	☐ No	☐ Don't know
4.	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

5. Have you ever received the following vaccinations? (Check all that apply.)

- ☐ COVID-19 (SARS-CoV-2): Date received _____
- ☐ Herpes zoster (shingles): Date received _____
- ☐ Influenza (flu): Date received _____
- ☐ Pneumococcal (pneumonia): Date received _____
- ☐ Respiratory syncytial virus (RSV): Date received _____
- ☐ Tetanus, diphtheria and pertussis (Tdap): Date received _____
- ☐ Other(s): _____ Date received _____

6.	Have you received any vaccinations in the past eight weeks? If yes, please list: _____	☐ Yes	☐ No	☐ Don't know
7.	Do you have any chronic health condition(s), 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
8.	**For women:** Are you pregnant or considering becoming pregnant in the next month? If you are pregnant, please indicate which week of pregnancy you are in: _____ (weeks)	☐ Yes	☐ No	☐ Don't know

For cholera, measles, mumps and rubella (MMR® II), varicella (chickenpox) and yellow fever vaccines only:
Answer the following questions only if you are receiving any vaccinations listed above.

9.	Do you have a condition that may weaken your immune system (e.g., cancer, leukemia, lymphoma, HIV/AIDS, transplant)?	Yes	No	Don't know
10.	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
11.	Are you currently taking high-dose steroid therapy (prednisone > 20mg/day or equivalent) for longer than 2 weeks?	Yes	No	Don't know
12.	Have you received a transfusion of blood or blood products or received immune globulin in the past 12 months?	Yes	No	Don't know
13.	**For cholera vaccine only:** Have you consumed any food or drink in the last hour?	Yes	No	Don't know
14.	**For cholera vaccine only:** Have you taken antibiotics in the last 14 days or antimalarials in the last 10 days?	Yes	No	Don't know
15.	**For MMR® II vaccine only:** Do you have a history of thrombocytopenia or thrombocytopenic purpura?	Yes	No	Don't know
16.	**For MMR® II vaccine only:** Have you received a skin test (TB) in the past 8 weeks?	Yes	No	Don't know
17.	**For yellow fever vaccine only:** Do you have a history of thymus disease (including myasthenia gravis, DiGeorge syndrome or thymoma), or had your thymus removed?	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 Walgreens or Duane Reade and the immunizer 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. Walgreens 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)

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SECTION D — INSURANCE–PATIENT OR AUTHORIZED PERSON TO COMPLETE

Please make sure to record BOTH pharmacy AND medical insurance information since there are multiple ways vaccinations can be billed at Walgreens.

	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: Please complete both fields
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: _____

SECTION E — PHARMACIST OR REGISTERED NURSE ONLY

Complete BEFORE vaccine administration

1. I have reviewed the **Patient Information and Screening Questions**. I have made every attempt to obtain and confirm patient insurance information. Initial here: _____
2. I have verified the **specific vaccine(s) requested** by the patient. Initial here: _____
3. This vaccine is appropriate for this patient based on the **Guidelines** provided by federal and/or state regulations, company policies, Immunization Selection Tool (IST) and as noted in the **state-specific vaccine tables**. Initial here: _____

   3a. If applicable, does this patient have a high-risk medical condition that supports administering the requested vaccine(s)? If yes, please list medical condition(s): _____ Initial here: _____
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. I have verified that the NDC of each vaccine being administered matches the NDC on the bottom of this VAR form and each patient prescription leaflet **(Perform a 3-way NDC match for all 3 items listed and for each vaccine administered)**. Initial here: _____
6. I have verified the **Expiration Date and Beyond Use Date** is greater than today's date and have entered the **Manufacturer Lot # and Expiration Date** in Section G below. Initial here: _____

   Enter that BUD here (if applicable) _____ and **for all reconstituted vaccines, please ensure the vaccine is properly prepared with the correct diluent following the manufacturer package insert instructions**.

SECTION F

Complete DURING the patient interaction

1. I have asked the patient to verbally confirm their **Name, DOB and Requested Vaccine** and verified that it matches the vaccine product information on the VAR form. (Perform a 3-way NDC match for each and every vaccine product.) Initial here: _____
2. I have verbally reviewed the **Screening Questions (Section B)** with the patient. Initial here: _____
3. I have reviewed and provided the **VIS/Patient Fact Sheet** to the patient. Initial here: _____

SECTION G

Complete all fields AFTER vaccine administration, if applicable

Vaccine	NDC	Manufacturer	Dosage	Dose number	Site of administration	Vaccine manufacturer lot number	Vaccine expiration	Diluent lot number	Diluent expiration	VIS/EUA Patient Fact Sheet published date

Pharmacist/registered nurse name (print required): First name: _____ **Last name:** _____

Pharmacist/registered nurse (signature required): _____ **Title:** _____

Immunizer name (print required): First name: _____ **Last name:** _____

Immunizer (signature required): _____ **Title:** _____ **Immunizer employee ID# (EID-required):** _____

Administration date: _____ **Date VIS/EUA Patient Fact Sheet given to patient:** _____

Notes

Reminder

1. Update the patient profile with any new allergy, health condition or primary care provider information.
2. After the vaccine has been administered and sold at POS, search for the patient in the IC+ Work Queue.
3. Select Options > Vaccine Info and answer all questions related to the vaccine administration and scan the VAR form into IC+.
4. File completed VAR forms in the designated record keeping area.