Vaccine Administration Record (VAR) Informed Consent

1300 Sunset Blvd
West Columbia, SC 29169
Phone: 803.791.7043

PATIENT INFORMATION

First Name:	Last Name:	DOB:	Age:	Gender: ☐ Male ☐ Female
Home Address:		City:	State:	Zip:
Home Phone:	Cell Phone:			

Race/Ethnicity:
☐ Native American ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ White ☐ Hawaiian/Pacific Islander ☐ Other

Primary Care Physician:	Physician Phone Number (if known):

I would like to receive the following vaccine(s):
☐ Flu Shot ☐ High Dose Flu Shot (ages 65+) ☐ Pneumonia ☐ Shingles ☐ Tdap ☐ Other:________________

ON-SITE CLINIC PAYMENT INFORMATION

MEDICARE IDENTIFICATION NUMBER:

MEDICARE PATIENTS ONLY:
I do hereby authorize Medicine Mart Pharmacy of West Columbia to release information and request payment for immunizations services. I certify that the information given by me in applying for payment under Medicare or any 3rd party is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf. Should any information provided prove incorrect thus denying payment, I personally guarantee payment for services rendered on my behalf and may be billed accordingly.

Signature (patient or legal representative):____ **Date:** _________________________

INSURANCE ID	BIN	PCN	GROUP

CREDIT OR DEBIT CARD NUMBER	EXPIRATION	CVV

SCREENING QUESTIONS (a*ll, non-live vaccines*)

1.	Are you currently sick today with a moderate to high fever, vomiting and/or diarrhea?	☐ Yes ☐ No
2.	Have you ever fainted or felt dizzy when receiving a vaccine?	☐ Yes ☐ No
3.	Have you ever had a serious reaction after receiving a vaccine?	☐ Yes ☐ No
4.	Do you have any of the following health conditions: heart disease, lung disease, asthma, kidney disease, neurologic disease, liver disease, diabetes, anemia or other blood disorder?	☐ Yes ☐ No
5.	Do you have a weakened immune system because of HIV/AIDS, another immune disorder, long-term treatment with high dose steroids, or cancer treatment with radiation or drugs?	☐ Yes ☐ No
6.	Do you have allergies to medications, foods, or vaccines? (Ex: eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast, thimerosal, etc.) If yes, please list:	☐ Yes ☐ No
7.	Have you received any vaccines or skin tests in the past four weeks? If yes, please list:	☐ Yes ☐ No
8.	Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-Barré syndrome or other nervous system problems?	☐ Yes ☐ No
9.	*For women:* Are you pregnant or considering becoming pregnant in the next month?	☐ Yes ☐ No

AUTHORIZATION / SIGNATURE

This pharmacy is providing necessary vaccines to you in a safe and convenient setting in order to promote adherence to current immunization guidelines recommended by the CDC and ACIP. It does not take the place of an ongoing relationship with your primary care provider to address ongoing medical issues and other types of preventive care. We are providing your primary care provider with records of the vaccine(s) administered here so that your medical records may be complete, but be sure to take your personal record with you to your next appointment as well. Please review the statement below confirming your consent for vaccination and provide the information as requested: I have read, or had explained to me, the Vaccine Information Sheet (VIS) for the vaccine(s) I wish to receive today. I understand the risks and benefits, and have been provided an opportunity to ask questions, which have been answered to my satisfaction. I wish to receive the vaccine(s) listed above and hereby give consent for a pharmacist or pharmacy intern at Medicine Mart Pharmacy to administer the vaccine(s) and communicate the administration of the vaccine to my primary care practitioner, who is listed above.

Signature (patient or legal representative):____ **Date**:____________________

FOR PHARMACY USE ONLY

I have verified the immunization(s) that the patient requested meets state, age and vaccine restrictions. Initial Here: ______
I have verified the requested immunization(s) is the same as the product prepared. Initial Here: ______
I have verified the expiration date of the product is greater than today's date. Initial Here: ______
I have provided the patient with a personal immunization record. Initial Here: ______ or patient declined

Vaccine #1:
VIS Date:
Method: IM / SQ
Location: Right / Left Arm
Manufacturer:
Lot #:
Exp Date:

Affix label(s) here:

Vaccine #2:
VIS Date:
Method: IM / SQ
Location: Right / Left Arm
Manufacturer:
Lot #:
Exp Date:

PharmD/RPh Name (print):_______________________License #:__________
Signature:____

Intern Name, if applicable (print):___________________________________
Signature:____

Administration Date:____________ Date VIS given to pt: ____________
Date reported to SC Immunization Registry:____________

Follow-up notes: