Vaccine Administration Record (VAR)—Informed Consent for Vaccination

SECTION A Please print clearly.

First name:____________________ **Last name:**____________________

Date of birth:__________ **Age:**_____ **Gender:** ☐ Female ☐ Male ☐ Non Binary ☐ Not Identified ☐ Other

Phone: ____________________

Home address:____________________ **City:** ____________________

State: _______ **ZIP code:**_______

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Native Hawaiian or Other Pacific Islander ☐ Other Race ________________ ☐ Unknown

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

I want to receive the following vaccination(s):

☐ TDAP (Tetanus) ☐ Hep B ☐ Flu ☐ Gardasil ☐ Hep A/B Combo ☐ Moderna ☐ Pfizer ☐ Pneumococcal ☐ RSV ☐ Shingrix

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. 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, neomycin, phenol, yeast or thimerosal)? ☐ Yes ☐ No ☐ Don't know

   If yes, please list:____________________
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. Do you have any chronic health condition such as cancer, chronic kidney disease, immunocompromised, chronic lung disease, obesity, sickle cell disease, diabetes, heart disease? ☐ Yes ☐ No ☐ Don't know

   If yes, please list:____________________
6. For women: Are you pregnant or considering becoming pregnant in the next month? ☐ Yes ☐ No ☐ Don't know

For COVID-19 vaccine only

7. Have you been treated with antibody therapy specifically for COVID-19 (monoclonal antibodies or convalescent plasma)? ☐ Yes ☐ No ☐ Don't know
8. Was your most recent COVID-19 vaccine dose at least 2 months ago? ☐ Yes ☐ No ☐ Don't know

For chickenpox, MMR II,® or shingles:
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 been given a medication called immune (gamma) globulin in the past year? ☐ Yes ☐ No ☐ Don't know
13. Do you have a history of thrombocytopenia or thrombocytopenic purpura? (MMR only) ☐ Yes ☐ No ☐ Don't know

SECTION C

I was offered the Vaccine Information Statement(s) for the vaccine(s) to be given and I have had all of my questions answered. I request that the vaccine be given to me or to the person named above, for whom I am responsible. I allow the release of any information needed to process insurance claims and request payments of medical benefits.

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

Office Use Only

VFC Eligible ☐ Yes ☐ No

Site: ☐ Left ☐ Right ☐ Deltoid ☐ Arm

VIS: __________

Route: ☐ IM ☐ SQ

Lot: __________

Administered by: ____________________ **Date:** __________