

Vaccine Administration Record (VAR) Informed Consent



PATIENT/CAREGIVER: Complete sections A-D

PROVIDER: Complete section E

Section A Please print clearly. Please fill out as much as possible

First name: _____ Last: _____ Middle: _____ Date of Birth: _____ Age: _____

Gender: _____ Ethnicity (select one): Hispanic or Latino Not Hispanic or Latino

Race (select one): Native American or Alaska Native Asian Black or African American Native Hawaiian or other Pacific Islander White or Caucasian Other

Language spoken: _____ Home phone: _____ Mobile: _____

Home address: _____ City: _____ State: _____ Zip code: _____

Email address: _____ Medication allergies: _____

Doctor/primary care provider name: _____ Doctor phone number: _____

Doctor address: _____ City: _____ State: _____

I want or child/teen needs to receive the following vaccine(s): Flu (influenza) COVID-19 Vaccine Pneumonia (pneumococcal) Shingles (herpes zoster) Hepatitis A/B Human Papillomavirus (HPV) Tetanus/Diphtheria/Whooping cough (Td, Tdap) Meningitis (meningococcal) **USE LIVE VACCINE VAR FORM FOR MMR, VARICELLA, LAIV, YELLOW FEVER**

Section B The following questions will help us determine your eligibility to be vaccinated today [Advisory Committee on Immunization Practices (ACIP)] If receiving a COVID-19 Vaccine, please complete **Prevaccination Checklist for COVID-19 Vaccine**

All vaccines	
1. Are you or child/teen sick today?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
2. Do you or child/teen have any allergies to medications, foods, vaccine components, or latex? If yes, please list:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
3. Have you or child/teen ever had a serious reaction (for example, anaphylaxis) after receiving a vaccine?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
4. Have you or child/teen ever fainted or felt dizzy after receiving a vaccine?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
5. Have you or child/teen had a seizure, brain disorder, Guillain-Barre syndrome, or other nervous system problem?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
6. For Females: Are you or teen pregnant or is there a chance of becoming pregnant during the next month?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know

Section C

I certify that I am: (a) the patient and at least 18 years of age or the age of consent to receive medical treatment under applicable state law; (b) the legal guardian or authorized representative of the patient; or (c) a representative of a facility in which the patient resides and, based upon clinical observation, have sufficient knowledge of the patient's condition to answer the screening questions provided above. **Pharmacy Contact.** By providing my telephone number to Genoa Healthcare on this consent form, I agree to receive pharmacy contact related to my health care or any follow-up appointments for any required multiple-dose vaccine regimens from Genoa Healthcare and its affiliates. **Consent to Receive Vaccines from a Genoa Pharmacist.** I hereby give my consent to the healthcare provider of Genoa, as applicable, to administer the vaccine that I have requested above (the "Vaccine"). I understand the risks and benefits associated with the Vaccine and have received, read and/or had explained to me the Vaccine Information Statements on the Vaccine that 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. **Limitation of Liability.** By signing this document, on behalf of myself, my heirs and personal representatives, I hereby release and hold harmless Genoa, 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). **Disclosure of Records.** I understand that Genoa may be required to or may voluntarily disclose my immunization information to any applicable state or federal immunization registry for the purpose of public health reporting, or to my healthcare providers for the purpose of care coordination. I authorize Genoa, as applicable, to release my medical or other information, including my communicable disease (including HIV), mental health and drug/alcohol abuse information, to my healthcare professionals, Medicare, Medicaid, or other third-party payer as necessary to effectuate care or payment. **HIPAA Acknowledgement.** By signing below, I acknowledge that I have received a copy of Genoa's currently effective Notice of Privacy Practices, which sets forth the types of uses and disclosures of my personally identifiable health information that Genoa is permitted to make. **Billing and Payment.** 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 Genoa invoices me after the time of service, upon receipt of such invoice. **Patient Acknowledgement.** I represent that I have read and fully understood the contents above, and I have freely and voluntarily signed this consent form. In addition, if I am signing on behalf of the patient, I certify that I am: (a) legally authorized to provide the required consents on behalf of the patient; or (b) facility personnel that has received verbal consent from the patient's legal guardian or authorized representative, _____ (name of the patient's legal guardian or authorized representative) to sign this VAR on behalf of the patient.

Printed name: _____ Signature: _____ Date: _____

Section D

Please ensure to record BOTH pharmacy AND medical insurance information. If you are not the recipient, please answer on behalf of the individual receiving the vaccine.

	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
Medicare number*:	

*Number on the red, white, and blue Medicare card

Check here if you currently under hospice care

Individuals receiving Flu or COVID vaccine who are uninsured please check here

Section E Healthcare Provider Only

Complete BEFORE vaccine administration *Confirm manufacturer-specific dosing and immunization schedules prior to administration
*Immunizer: Write in vaccine type/name, route, dose per approved age, lot #, and expiration date for any vaccine not listed

I have verified the vaccine(s) that the patient requested meets state, age and vaccine restrictions	Initial here:
I have verified the requested vaccine(s) is the same as the product prepared	Initial here:
I have verified the expiration date of the vaccine(s) is greater than today's date	Initial here:
I have reconstituted the vaccine(s) following the package insert's instructions	Initial here:
AZ ONLY: I have reviewed the patient record for vaccine history and adverse events in the State Immunization Information System (IIS)	Initial here

Complete BEFORE vaccine administration *Confirm manufacturer-specific dosing and immunization schedules prior to administration. Refer to Genoa VAR dosing guide supplement [HERE](#)

Complete AFTER vaccine administration

Vaccine	Manufacturer	NDC	Dosage	Site of Injection (circle site)	VIS Date	Lot #	Expiration Date
				L / R IM / SC Deltoid / Thigh / Upper Arm			
				L / R IM / SC Deltoid / Thigh / Upper Arm			
				L / R IM / SC Deltoid / Thigh / Upper Arm			

Administration Date: _____ Date VIS Given to Patient: _____

Immunizer/Supervising Pharmacist Signature: _____

Immunizer Name (print): _____ Title: _____

If Applicable, Intern or Technician Name (print): _____

If Applicable, PCP Notified (Date/Time): _____

Recipient does not have/did not indicate a primary care physician

Substitution permitted

Dispense as Written



Prevaccination Checklist for COVID-19 Vaccination



Name _____

For vaccine recipients (both children and adults):

The following questions will help us determine if there is any reason COVID-19 vaccine cannot be given today.

If you answer "yes" to any question, it does not necessarily mean the vaccine cannot be given. It just means additional questions may be asked. If a question is not clear, please ask the healthcare provider to explain it.

	Yes	No	Don't know
1. How old is the person to be vaccinated? _____			
2. Is the person to be vaccinated sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the person to be vaccinated ever received a dose of COVID-19 vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> If yes, which vaccine product was administered? <ul style="list-style-type: none"> <input type="checkbox"/> Pfizer-BioNTech <input type="checkbox"/> Janssen (<i>Johnson & Johnson</i>) <input type="checkbox"/> Another Product <input type="checkbox"/> Moderna <input type="checkbox"/> Novavax 			
<ul style="list-style-type: none"> How many doses of COVID-19 vaccine were administered? _____ 			
<ul style="list-style-type: none"> Did you bring the vaccination record card or other documentation? 	<input type="checkbox"/>	<input type="checkbox"/>	
4. Does the person to be vaccinated have a health condition or is undergoing treatment that makes them moderately or severely immunocompromised? <i>This would include, but not be limited to, treatment for cancer, HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematopoietic cell transplant [HCT], or moderate or severe primary immunodeficiency.</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Has the person to be vaccinated received COVID-19 vaccine before or during hematopoietic cell transplant (HCT) or CAR-T-cell therapies?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Has the person to be vaccinated ever had an allergic reaction to: <i>(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)</i>			
<ul style="list-style-type: none"> A component of a COVID-19 vaccine 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> A previous dose of COVID-19 vaccine 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Has the person to be vaccinated ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? <i>(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Check all that apply to the person to be vaccinated:			
<input type="checkbox"/> Have a history of myocarditis or pericarditis			
<input type="checkbox"/> Have a history of Multisystem Inflammatory Syndrome (MIS-C or MIS-A)?			
<input type="checkbox"/> History of an immune-mediated syndrome defined by thrombosis and thrombocytopenia, such as heparin-induced thrombocytopenia (HIT)			
<input type="checkbox"/> Have a history of thrombosis with thrombocytopenia syndrome (TTS)			
<input type="checkbox"/> Have a history of Guillain-Barré Syndrome (GBS)			
<input type="checkbox"/> Have a history of COVID-19 disease within the past 3 months?			
<input type="checkbox"/> Vaccinated with monkeypox vaccine in the last 4 weeks?			

Form reviewed by _____

Date _____