Immunization Informed Consent and Vaccine Administration Record (VAR) for Good Neighbor Pharmacy Pharmacists

PATIENT: COMPLETE SECTIONS A, B, C

PROVIDER: COMPLETE SECTION D (reverse side)

SECTION A

(Please print clearly.)

First name: _____ **Last name:** _____ **Date of birth:** _____ **Age:** _____

Gender: ☐ Female ☐ Male **Home phone:** _____ **Mobile phone:** _____

Race (select one or more)

☐ Native American or Alaska Native ☐ Asian ☐ Black or African-American ☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Other

Ethnicity (select one)

☐ Hispanic or Latino ☐ Not Hispanic or Latino

Home address: _____ **City:** _____ **State:** _____ **ZIP code:** _____

Email address: _____

Doctor/primary care provider name: _____ **Phone number:** _____

Address: _____ **City:** _____ **State:** _____ ☐ I do not have a primary care doctor/provider

I want to receive the following immunization(s):

☐ Flu (influenza) ☐ Pneumonia (pneumococcal) ☐ Shingles (herpes zoster) ☐ Tdap (whooping cough) ☐ Other: _____

SECTION B

The following questions will help us determine your eligibility to be vaccinated today. For all vaccines: Please answer questions 1-7. For live vaccines (e.g., MMR or shingles): Please answer questions 1-14. For flu nasal spray: Please answer questions 1-17.

All vaccines				
1.	Are you currently sick with a moderate to high fever, vomiting/diarrhea?	☐ Yes	☐ No	☐ Don't know
2.	Have you ever fainted or felt dizzy after receiving an immunization?	☐ Yes	☐ No	☐ Don't know
3.	Have you ever had a reaction after receiving an immunization?	☐ Yes	☐ No	☐ Don't know
4.	Do you have an immunocompromising condition (e.g., cancer, leukemia, lymphoma, HIV/AIDS, transplant), functional, or anatomic asplenia, CSF leak or cochlear implant?	☐ Yes	☐ No	☐ Don't know
5.	Do you have allergies to latex, medications, food or vaccines? (Examples: eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal) a. If yes, please list: _____	☐ Yes	☐ No	☐ Don't know
6.	Have you ever had a seizure disorder for which you are on seizure medications, a brain disorder, Guillain-Barré syndrome or other nervous system problems?	☐ Yes	☐ No	☐ Don't know
7.	**For women:** Are you pregnant or considering becoming pregnant in the next month?	☐ Yes	☐ No	☐ Don't know
Live vaccines (Chicken pox, flu nasal spray, MMR, oral typhoid, shingles, Yellow fever) Only answer these questions if you are receiving any immunization listed above.				
8.	Are you currently on home infusions, weekly injections (such as adalimumab, infliximab and etanercept), high-dose methotrexate, azathioprine or 6-mercaptopurine, antivirals, anticancer drugs or radiation treatments?	☐ Yes	☐ No	☐ Don't know
9.	Have you received any vaccinations or skin tests in the past four weeks? a. If yes, please list: _____	☐ Yes	☐ No	☐ Don't know
10.	Have you received a transfusion of blood, blood products or been given a medication called immune (gamma) globulin in the past year?	☐ Yes	☐ No	☐ Don't know
11.	Are you currently taking high-dose steroid therapy (prednisone >20mg/day or equivalent) for longer than two weeks?	☐ Yes	☐ No	☐ Don't know
12	Do you have a history of thymus disease (including myasthenia gravis), thymoma or prior thymectomy? (Yellow fever only)	☐ Yes	☐ No	☐ Don't know
13.	Are you currently taking any antibiotics or antimalarial medications? (Oral typhoid only)	☐ Yes	☐ No	☐ Don't know
14.	Do you have a history of thrombocytopenia or thrombocytopenic purpura? (MMR only)	☐ Yes	☐ No	☐ Don't know
Flu nasal spray (FluMist® Quadrivalent)				
15.	For patients 18 years of age and younger only: Are you receiving aspirin therapy or aspirin-containing therapy?	☐ Yes	☐ No	☐ Don't know
16.	For patients 5 years of age and younger only: Is there a history of asthma or wheezing?	☐ Yes	☐ No	☐ Don't know
17.	Do you have a nasal condition serious enough to make breathing difficult, such as a very stuffy nose?	☐ Yes	☐ No	☐ Don't know

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 Mackenthun's Pharmacy as applicable, 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 Mackenthun's Pharmacy 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) listed above. I acknowledge that: (a) I understand the purposes/benefits of my state's immunization registry ("State Registry") and my state's health information exchange ("State HIE"); and Mackenthun's, as applicable, may disclose my immunization 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 health care 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, a _____ opt-out form ("Opt-Out Form"): (a) the disclosure of my immunization information by Mackenthun's to the State HIE and/or State Registry; or (b) the State HIE and/or State Registry from sharing my immunization information with any of my other healthcare providers enrolled in the State Registry and/or State HIE. Mackenthun's as applicable, 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 Mackenthun's, as applicable, reporting my immunization 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 Mackenthun's as applicable, 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 Mackenthun's 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 immunization information to or through the State HIE as required or permitted by law. I also authorize Mackenthun's, as applicable, 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 immunization 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 Mackenthun's as applicable, 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 Mackenthun's as applicable, with respect to the above requested items and services. **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 Mackenthun's invoices me after the time of service, upon receipt of such invoice.**

Signature: _____ **Date:** _____

(Parent or guardian, if minor)