Vaccine Administration Record (VAR)
Informed Consent for Vaccination for All Healthcare Providers

PATIENT TO FILL OUT SECTIONS A, B & C

SECTION A (Please print clearly.)

First Name: _____ Last Name: _____

Date of Birth: ____/_____/_____ Age: _____ Gender: ☐ Female ☐ Male ☐ Other

Home Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____

Home Address: _____ City: _____

State: _____ Zip: _____

Doctor/Primary Care Physician/Provider Name: _____

Phone Number: _____ Mother's Maiden name: _____

I want to receive the following immunization(s) today:

_____

SECTION B

The following questions will help us determine your eligibility to be vaccinated today. For all vaccines, please answer questions 1-6. For live vaccines (e.g. MMR), please answer questions 7-12.

All Vaccines----------

1. Do you feel sick today? ☐ Yes ☐ No ☐ Don't Know

2. Have you ever fainted or felt dizzy when receiving an immunization? ☐ Yes ☐ No ☐ Don't Know

3. Have you ever had a serious reaction after receiving an immunization? ☐Yes ☐ No ☐ Don't Know

4. Do you have allergies to latex, medications, food or vaccines? ☐ Yes ☐ No ☐ Don't Know
(Examples: eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal)
a. If Yes, please list: _____

5. Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Gullian-Barré Syndrome or other nervous system problems? ☐ Yes ☐No ☐ Don't Know

6. Are you pregnant or considering becoming pregnant in the next month: ☐Yes ☐ No ☐ Don't Know

Live Vaccines (MMR, oral typhoid)----------

7. Have you received any vaccinations or skin tests in the past four weeks? (Including MMR, Oral Typhoid, Varicella) ☐ Yes ☐ No ☐ Don't Know
If yes, please list: _____

8. Are you currently on home infusions, weekly injections (such as adalimumab, infliximab and etanercept), high dose methotrexate, prednisone >20mg/day, azathioprine or 6-MP, antivirals, anticancer drugs or radiation treatments?_____☐ Yes ☐ No ☐ Don't Know

10. Do you have cancer, HIV/AIDS or any other immune system disorder? ☐ Yes ☐ No ☐ Don't Know

11. Have you received a transfusion of blood or blood products or been given a medicine called immune gamma Globulin in the past year? ☐ Yes ☐ No ☐ Don't Know

12. For patients 18 years of age and younger only: Are you receiving aspirin therapy or aspirin-

containing therapy? ☐ Yes ☐ No ☐ Don't Know

SECTION C

I certify that I am: (1) the Patient and at least 18 years of age; (2) the parent or legal guardian of the minor Patient; or (3) the legal guardian of the Patient. Further, I hereby give my consent to the healthcare provider at Desert Life Pharmacy 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/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 health provider. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless Desert Life 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 purpose/benefits of my state's immunization registry ("Registry"); (b) I may, if my state permits, object to Desert Life Pharmacy disclosing my immunization information to the Registry by providing Desert Life Pharmacy with a state approved Registry disclosure opt out form; and (c) Unless I authorize Desert Life Pharmacy, as applicable, to (i) 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, (ii) submit a claim to my insurer for the above requested items and services, and (iii) request payment of authorized benefits be made on my behalf to Desert Life Pharmacy LLC., as applicable, with respect to the above requested items and services. I further agree to be fully financially responsible for any co-sharing amounts, including co-pays, 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, Desert Life Pharmacy, invoices me after the time of service, upon receipt of such invoice.

Patient Signature: _____ Date: _____
(Parent or Guardian, if minor)
Patient name/Relationship (if minor): _____

SECTION D IMMUNIZER ONLY: Complete BEFORE vaccine administration.

Vaccine	NDC	DOSE	ROUTE	LOT/EXP	VIS DATE
			L / R IM / SC		
			L / R IM / SC		
			L / R IM / SC		
			L / R IM / SC		

Immunizer Name (print): _____

Immunizer Signature: _____Date: _____