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 ☐ RSV
☐ 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)].

Section C

All vaccines	
1. Are you or child/teen sick today?	☐ Yes ☐ No ☐ Don't Know
2. Do you or child/teen have any allergies to medications, foods, vaccine components, or latex? If yes, please list:	☐ Yes ☐ No ☐ Don't Know
3. Have you or child/teen ever had a serious reaction (for example, anaphylaxis) after receiving a vaccine?	☐ Yes ☐ No ☐ Don't Know
4. Have you or child/teen ever fainted or felt dizzy after receiving a vaccine?	☐ Yes ☐ No ☐ Don't Know
5. Have you or child/teen had a seizure, brain disorder, Guillain-Barre syndrome, or other nervous system problem?	☐ Yes ☐ No ☐ Don't Know
6. **For Females:** Are you or teen pregnant or is there a chance of becoming pregnant during the next month?	☐ Yes ☐ No ☐ Don't Know
COVID-19 ONLY	
7. Have you ever been diagnosed with a heart condition (myocarditis or pericarditis), or have you had Multisystem Inflammatory Syndrome (MIS-A or MIS-C) after an infection with the virus that causes COVID-19?	☐ Yes ☐ No ☐ Don't Know

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 a 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 and/or prepared the vaccine(s) for administration according to 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 all that apply)*	Route of Administration *(circle one)*	VIS Date	Lot #	Expiration Date
				L / R Deltoid / Thigh / Upper Arm	IM / SC			
				L / R Deltoid / Thigh / Upper Arm	IM / SC			
				L / R Deltoid / Thigh / Upper Arm	IM / SC			

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

genoa healthcare®