

Vaccine Administration Record (VAR)



Informed Consent for Vaccination in Long Term Care Facility (LTCF)

SECTION A-1 Please print clearly.

First name: Last name: Date of birth: Age: Gender: Female Male Phone: LTCF Name: Address: City: State: ZIP code: Patient Email address:

I want to receive the following vaccination(s): COVID-19 Vaccination

SECTION A-2 I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient; or (c) a person authorized to consent on behalf of the patient where the patient is not otherwise competent or unable to consent for themselves.

I acknowledge that: (a) I understand the purposes/benefits of my state's vaccination registry ("State Registry") and my state's health information exchange ("State HIE"); and (b) the applicable Provider may disclose my vaccination information to the State Registry, to the State HIE, or through the State HIE to the State Registry, or to any state or federal governmental agencies or authorities ("Government Agencies").

I understand that even if I do not consent or if I withdraw my consent, my state's laws or federal law may permit certain disclosures of my vaccination information to or through the State HIE or to Government Agencies as required or permitted by law.

Print Name: Patient/Authorized Person signature: Date:

SECTION B-1 SCREENING QUESTIONS. The following questions will help us determine your eligibility to be vaccinated today.

- 1. Do you feel sick today?
2. Do you have any health conditions, such as heart disease, diabetes or asthma?
3. Do you have allergies to latex, medications, food or vaccines (examples: eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal)?
4. Have you ever had a reaction after receiving a vaccination, including fainting or feeling dizzy?
5. 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?
6. For women: Are you pregnant or considering becoming pregnant in the next month?

**SECTION B-2** I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient or representative of; or (c) a representative of the LTCF and, based upon clinical observation, have sufficient knowledge of the patient's condition to answer the Screening Questions. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.

Patient/LTCF Representative: \_\_\_\_\_ Date: \_\_\_\_\_

**SECTION C INSURANCE – PATIENT TO COMPLETE IF APPLICABLE**

Please ensure to record BOTH pharmacy AND medical insurance information since there are multiple ways immunizations can be billed at Walgreens.

Non-Medicare:	Pharmacy Card	Medical Card	Medicare:	Medicare Part B
Insurance Plan/Plan ID:			Medicare Number*:	
Member/Recipient ID #:			*Medicare Claim Number for cards distributed earlier than 2018.	
RX BIN:		N/A		
RX PCN:		N/A		
Group Number:				

Is the patient the cardholder?  Yes  No

If no, please provide cardholders name, date of birth (MM/DD/YYYY) and relationship: \_\_\_\_\_

**SECTION D HEALTHCARE PROVIDER ONLY**

Complete **BEFORE** vaccine administration

- I have reviewed the **Patient Information** and **Screening Questions**. Initial here: \_\_\_\_\_
- I have verified that this is the **vaccine requested** by the patient. Initial here: \_\_\_\_\_
- This vaccine is appropriate for this patient based on the **Age Guidelines and Other Guidelines** provided by federal and/or state regulations and company policies. Initial here: \_\_\_\_\_
  - Does this patient have a high-risk medical condition?  Yes  No  
If yes, please list medical condition(s): \_\_\_\_\_
- The **Vaccine NDC matches** the NDC on the bottom of this VAR form and the NDC on the patient leaflet. (Perform **3-way NDC match**.) Initial here: \_\_\_\_\_
- I have verified the **Expiration Date** is greater than today's date and have entered the **Lot # and Expiration Date** in the field below. Initial here: \_\_\_\_\_

**SECTION E Complete DURING the patient interaction**

- I confirm(ed) the patient's **Name, DOB and Requested Vaccine** and verified it matches the information on the VAR form. Initial here: \_\_\_\_\_
- I have reviewed the **Screening Questions** and answers. Initial here: \_\_\_\_\_
- I provided a **EUA Fact Sheet** to the patient or the LTCF representative. Initial here: \_\_\_\_\_

**SECTION F**

Complete **AFTER** vaccine administration

Vaccine	NDC	Manufacturer	Dosage	<input type="checkbox"/> Dose 1	Site of administration	EUA Fact Sheet published date
				<input type="checkbox"/> Dose 2		

Clinician's name (print): \_\_\_\_\_ Clinician's signature: \_\_\_\_\_ Title: \_\_\_\_\_

If applicable, intern/tech name (print): \_\_\_\_\_ Administration date: \_\_\_\_\_ Date EUA Fact Sheet given to patient: \_\_\_\_\_

COVID-19 VACCINE LOT# \_\_\_\_\_ COVID-19 VACCINE EXPIRATION DATE \_\_\_\_\_

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- Update the patient's record with any new allergy, health condition or primary care provider information.
- Enter vaccine lot #, expiration date and site of administration, then scan the VAR form into the patient's record.