VACCINE ADMINSTRATION RECORD (VAR)- INFORMED CONSENT FOR VACCINATION

ALL information must be Completed

Patient Name: _____ **Date of Birth**_____	**Sex:** _____ **Phone Number:** _____
Address:_____ **Race:** _____ **Ethnicity:** _____	**Rx BIN** _____ **Rx PCN** _____ **Rx Group** _____ **Rx ID**_____ **Prescription Insurance Provider**_____
Vaccine(s) receiving today: _____	**SSN#** _____ **Email:** _____

1.	Do you feel sick today?	☐ Yes ☐ No ☐ Don't Know
2.	Do you have a history of allergic reaction or allergies to latex, medications, food or vaccines (example: polyethylene glycol, polysorbate, eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal)? If yes, please list :	☐ Yes ☐ No ☐ Don't Know
3.	Have you ever had a reaction after receiving a vaccination that includes severe allergic reactions that required administration if epinephrine or EpiPen or that caused you to go to hospital? Or any reaction that occurred within 4 hours which caused hives, swelling or respiratory distress including wheezing?	☐ Yes ☐ No ☐ Don't Know
4.	Have you received any vaccinations in the past 2 weeks? If yes, please list:	☐ Yes ☐ No ☐ Don't Know
5.	Do you have any chronic health conditions like Cancer, Chronic Kidney Disease, Immunocompromised, Chronic Lung Disease, Obesity, Sickle Cell Disease, Diabetes, or Heart Disease? If yes, please list:	☐ Yes ☐ No ☐ Don't Know
6.	Do you have a bleeding disorder or are you taking blood thinners?	☐ Yes ☐ No ☐ Don't Know
7.	Have you experienced seizures, Guillain-Barre Syndrome or any other neurological disorder?	☐ Yes ☐ No ☐ Don't Know
8.	Have you received the following vaccines? If so, please list the date ☐ Pneumonia: Date received_____ ☐ Shingles: Date received_____ ☐ Whooping Cough/ TdaP: Date received_____	
9.	**For women:** Are you pregnant or considering becoming pregnant in the next month?	☐ Yes ☐ No ☐ Don't Know

10. For COVID- Vaccine only: a) When was your last dose of COVID vaccine, if any? b) Which vaccine did you receive? c) Have you been treated with an antibody therapy specifically for COVID- 19 (monoclonal antibodies or convalescent plasma)?	☐ Yes ☐ No ☐ Don't Know

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. Further, I hereby give my consent to Beacon Prescriptions and the licensed healthcare professional administering the vaccine to administer vaccine (s). 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 EUA Fact Sheet 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. I further authorize the applicable Provider to: (a) release my medical or other information, including any communicable disease (including HIV) and mental health information, to, or through, the State HIE or Government Agencies 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 the applicable Provider with respect to the above requested items and services. I further agree to be fully financially responsible for any cost-sharing 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.

Signature of patient (parent/guardian, if minor) _____ Date: _____

Print Name (If signing for someone else) _____ Relationship to Patient: _____

Vaccine	Manufacturer	Dosage (ml)	Site of administration (LA/RA)	Vaccine Lot	Vaccine Expiration	Immunizer	Date