Place Rx Label Here
(Pharmacy Use Only)

Vaccine Administration Record (VAR)

SECTION 1: Patient Information

Name: ____ **Date of Birth**: ____________________ **Gender**: ☐ Female ☐ Male

Address: ______________________________________ **City**: _____________________ **State**: _______ **Zip Code**: ______________

Phone Number: __________________________ **SSN**: _______________________ **Ethnicity**: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Pacific Islander or Native Hawaiian ☐ Other

SECTION 2: Immunization Questionnaire *(Questions pertain to person to be vaccinated)*

Question	Answer
1. Are you sick today?	☐ Yes ☐ No ☐ Unsure
2. Within the last 14 days, have you felt ill with fever, cough, or shortness of breath; or tested positive for COVID-19 or had exposure to someone who tested positive?	☐ Yes ☐ No ☐ Unsure
3. Do you have allergies to medications, food, latex, a vaccine ingredient (*examples*: polyethylene glycol, polysorbate, eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, or yeast)?	☐ Yes ☐ No ☐ Unsure
4. Have you ever had a serious reaction after receiving any vaccination? (*examples*: anaphylaxis, MIS, myocarditis)	☐ Yes ☐ No ☐ Unsure
5. Do you have any long-term health problems? (Check all that apply) ☐ Diabetes ☐ Lung Disease ☐ Heart Disease ☐ Kidney Disease ☐ Blood Disorder ☐ Asthma ☐ Asplenia ☐ Cochlear Implant ☐ Cerebrospinal Fluid Leak ☐ Other	☐ Yes ☐ No ☐ Unsure
6. Do you have cancer, leukemia, HIV/AIDS, asplenia, or another condition that may weaken the immune system?	☐ Yes ☐ No ☐ Unsure
7. In the past 3 months, have you had radiation treatments or taken medications that weaken the immune system? (*examples*: prednisone > 20mg/day or other steroid equivalent for longer than 2 weeks, anticancer drugs, Humira®, Remicade®, or Enbrel®, methotrexate, azathioprine)	☐ Yes ☐ No ☐ Unsure
8. Have you ever had a seizure, brain or nervous system disorder, or Guillain-Barre' Syndrome?	☐ Yes ☐ No ☐ Unsure
9. During the past year, have you received a transfusion of blood/blood products, or received immune (gamma) globulin?	☐ Yes ☐ No ☐ Unsure
10. **For women**: Are you pregnant, breastfeeding, or could be pregnant in the next month?	☐ Yes ☐ No ☐ Unsure
11. Have you received any vaccinations or skin tests (i.e. TB test) in the past 4 weeks?	☐ Yes ☐ No ☐ Unsure
12. Have you ever felt dizzy or faint before, during, or after a shot?	☐ Yes ☐ No ☐ Unsure
13. Do you have a history of thrombocytopenia or thrombocytopenia purpura?	☐ Yes ☐ No ☐ Unsure
14. **For children under 18 years old:** Is the child to be vaccinated on aspirin or aspirin-containing therapy?	☐ Yes ☐ No ☐ Unsure
15. Is the person to be vaccinated on antiviral medications?	☐ Yes ☐ No ☐ Unsure

SECTION 3: Consent for Vaccination

I certify that I am: (i) the patient & at least 18 years of age; (ii) the parent or legal guardian of the minor Patient: or (iii) the legal guardian of the Patient. Further I hereby give my consent to the healthcare provider of HomeTown Pharmacy to administer the vaccine(s) I have requested. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccines. I understand the risks and benefits associated with the requested vaccines & have received and understand the Vaccine Information Sheet for these vaccines. I also acknowledge that I have had chance to ask questions & that questions were answered to my satisfaction. Further I acknowledge that I have been advised to remain near the vaccination area for 15 minutes for observation by the administering health care provider. On behalf of myself, my heirs, and personal representatives, I hereby release & hold harmless HomeTown Pharmacy, its staff, agents & employees from any all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of these vaccines. I authorize HomeTown Pharmacy to release any medical or other information to my health care professionals, Medicare, Medicaid, or other third-party payor necessary to effectuate care or payment & request that payment of authorized benefits be made to HomeTown Pharmacy with respect to the vaccine(s) received. If it is determined that this vaccine is not a covered benefit, HomeTown Pharmacy may bill me directly for the vaccine & administration.

Signature: ______________________________________ **Date:**_______________

Parent/Guardian Name (PRINT): _________________________________ **Relationship to Patient:** ☐ Mother ☐ Father ☐ Parent ☐ Guardian ☐ Self

FOR PHARMACY USE ONLY

Vaccine	Manufacturer	Lot # / Expiration	Date on VIS	Site
1.				☐ Left ☐ Arm ☐ IM ☐ Right ☐ Leg ☐ SQ
2.				☐ Left ☐ Arm ☐ IM ☐ Right ☐ Leg ☐ SQ
3.				☐ Left ☐ Arm ☐ IM ☐ Right ☐ Leg ☐ SQ

Immunizer Signature: ____ **Date Immunization & VIS Provided:** _________________________