HOMETOWN PHARMACY

Vaccine Administration Record (VAR)

Section 1: Patient Information

Place Rx Label Here
(Pharmacy Use Only)

Name:_____ Date of Birth:_____

Address:_____ City:_____

Phone:_____ Zip Code:_____

Gender (Circle One): Male/ Female

Section 5: (For Office Use Only)

RPh Signature:_____

Date of Immunization and VIS given:_____

Section 2: Immunization Questionnaire (Please Select Yes or No) VIS Publication Date: _____

1. Within the last 14 days, has the person to be vaccinated felt ill with fever, cough, or shortness of breath; or tested positive for COVID-19 within the last 14 days or had recent exposure to someone who tested positive?	**Yes No**
2. Does the person to be vaccinated today have allergies to medications, eggs or other foods, latex or any vaccine component, including previous influenza vaccinations?	**Yes No**
3. Has the person to be vaccinated today ever had a serious reaction after receiving any vaccination?	**Yes No**
4. Does the person to be vaccinated today have any long-term health problems? (Please check all that apply) □ Diabetes □ Lung Disease □Heart Disease □Kidney Disease □Blood Disorder □Asthma □Other	**Yes No**
5. Does the person to be vaccinated today have cancer, leukemia, HIV/AIDs, or any other immune system problem?	**Yes No**
6. In the past 3 months, has the person to be vaccinated taken medications that weaken the immune system, i.e. prednisone, or other steroids (prednisone > 20mg/day or equivalent for longer than 2 weeks), anticancer drugs, Humira®, Remicade®, or Enbrel®, methotrexate, azathioprine, or have they had radiation treatments?	**Yes No**
7. Has the person to be vaccinated ever had a seizure, brain or nervous system disorder, or Guillain-Barre' Syndrome?	**Yes No**
8. During the past year, has the person to be vaccinated received a transfusion of blood or blood products, or been given immune (gamma) globulin?	**Yes No**
9. Does the person to be vaccinated today expect to have close contact with a person whose immune system is severely compromised?	**Yes No**
10. Is the person to be vaccinated on antiviral medications?	**Yes No**
11. **For women:** Is the person to be vaccinated pregnant, or could she become pregnant within the next month?	**Yes No**
12. **For children under 18 years old:** Is the child to be vaccinated on aspirin or aspirin-containing therapy?	**Yes No**
13. Has the person to be vaccinated today received any vaccinations or skin tests (i.e. TB test) in the past 4 weeks?	**Yes No**
14. Do you have a history of thrombocytopenia or thrombocytopenia purpura (MMR only)?	**Yes No**

Section 3: Consent for Vaccination:

I certify that I am: (i) the patient and 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 and have received and understand the Vaccine Information Sheet for these vaccines. I also acknowledge that I have had 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 area for 15 minutes for observation by the administering health care provider. On behalf of myself, my heirs, and personal representatives, I hereby release and hold harmless HomeTown Pharmacy, its staff, agents and 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 and 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 and administration

Signature:_____ **Date:**_____

Section 4: Vaccine Information (Pharmacy Use Only)

Vaccine	Manufacturer	Lot #/Expiration	Site
1.			**□Left □Arm □IM □Right □Leg □SQ**
2.			**□Left □Arm □IM □Right □Leg □SQ**
3.			**□Left □Arm □IM □Right □Leg □SQ**