

**Vaccine Administration Record (VAR) Informed Consent for Vaccination For All Health Care Providers\***

**PATIENT: COMPLETE SECTIONS A,B,C**

**SECTION A: (PLEASE PRINT CLEARLY)**

Cell Phone Date of Birth Age Gender

Male Female

First Name MI Last Name

Home Address City State Zip Code

Primary Care Physician Name Physician Phone

SECTION B: The following questions will help us determine your eligibility to be vaccinated today. For All Vaccines: Please answer questions 2-10.

**YES NO**

1. Which vaccines are you requesting to have administered today? (PLEASE CIRCLE): **1) FLU 2) PNEUMONIA (13 -OR- 23) 3) GARDASIL (HPV) 4) Tdap 5) Td (TETANUS)**

**6) SHINGRIX (SHINGLES) 7) VARICELLA (CHICKEN POX) 8) HEPATITIS A 9) HEPATITIS B 10) MENINGITIS B 11) MENINGITIS ACYW (REQUIRED) 12) MMR-II 13) IMOVAX (RABIES)**

1. Do you feel sick today? \_\_\_ \_\_\_
2. Do you have allergies to medications, food or any vaccine? (EX. Eggs, Bovine Protein, Gelatin, Gentamycin,

Polymyxin, Neomycin, Phenol or Thimerosal) **If Yes, Please List: \_\_\_ \_\_\_**

1. Have you received any vaccinations in the past 4 weeks**? If yes, Please list: \_\_\_ \_\_\_**
2. Have you ever had a serious reaction to an Influenza vaccine or any other vaccine in the past? \_\_\_ \_\_\_
3. Have you ever had a seizure disorder for which you take seizure medication(s),a brain disorder,

Guillain-Barre Syndrome, or other nervous system problem? \_\_\_ \_\_\_

1. Are you 65 years of age or older OR do you smoke OR have a chronic condition like asthma or diabetes? \_\_\_ \_\_\_
2. If you answered YES to question #7, have you ever had a pneumococcal, or “pneumonia” vaccination? \_\_\_ \_\_\_
3. Do you currently take any blood thinning medication (ex: Warfarin, Coumadin, Xarelto, etc) \_\_\_ \_\_\_
4. For Women: Are you pregnant or considering becoming pregnant in the next month? \_\_\_ \_\_\_

SECTION C:

I certify that I am: (a) the patient and at least 18 years of age; (b) the parent or legal guardian of the minor patient; or (c) the legal guardian of the patient. Further, I hereby give my consent to the health care provider of Keystone Pharmacy Services, D/B/A UT Student Health Center Pharmacy or an employee of the University of Tennessee, as applicable (each an “applicable Provider”), to administer the vaccine(s) I have requested above. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). 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, for purposes of public health reporting, or to my healthcare providers enrolled in the State Registry and/or State HIE for purposes of care coordination.

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. I understand that any payment for which I am financially responsible is due at the time of service or, if the applicable Provider invoices me after the time of service, upon receipt of such invoice.

I understand the risks and benefits associated with the above vaccine(s) and have received, read and/or had explained to me the Vaccine Information Statements on the vaccine(s) I have elected to receive. In addition 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. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless the applicable Provider, its staff, agents, successors, students, 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) listed above. I acknowledge that today I have received the Vaccine Information Sheet (VIS) provided by the CDC (Centers for Disease Control) which corresponds to the vaccine(s) received today.

**SIGNATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SECTION D: (HEALTH CARE PROVIDERS ONLY)** *The following section is to be completed by the health care provider only.*

Immunizer Name (Print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Immunizer Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_RPH/PharmD/Intern/MD/RN/LPN

Did the patient receive any prophylactic medication today (ex: Acetaminophen, Ibuprofen)? If so please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Vaccine** **Lot#** **Exp. Date** **Manufacturer** **Dosage** **Injection Site** **VIS Date**

0.5 mL L / R Deltoid IM / SUBQ \_\_\_\_\_\_\_

0.5 mL L / R Deltoid IM / SUBQ \_\_\_\_\_\_\_

0.5 mL L / R Deltoid IM / SUBQ \_\_\_\_\_\_\_