Vaccine Administration Record (VAR) Informed Consent for Vaccination for All Healthcare Providers [1]

PATIENT: COMPLETE SECTIONS A, B, C

Sterling PHARMACY

Section A *Please Print Clearly*

First Name _____ MI _____ Last Name _____ Gender: ☐ Male ☐ Female ☐ Prefer Not to Disclose

Date of Birth _____/_____/_____ Age _____ Home Phone (_____)_____ Email *(By providing your email, you agree to receive other communications from Sterling)* [2] _____

Home Address _____ City _____ State _____ Zip Code _____

Primary Care Physician (if known) _____ Physician Phone (_____)_____

Medicare Part B Number (if applicable) _____ Check Requested Vaccine: ☐ Flu Shot ☐ Flu Nasal Spray (live) *(Ages 2 to 49 only)* ☐ Other: _____

Section B *The following questions will help us determine your eligibility to be vaccinated today.*	**YES**	**NO**	**DON'T KNOW**
1. Do you feel sick today?			
2. Do you have allergies to medications, latex rubber, food, or any vaccine (e.g., eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, or thimerosal)? **If yes, please list the allergies:**			
3. Have you received any vaccinations in the past four weeks? **If yes, please list the immunization:**			
4. Have you ever had a serious reaction to an influenza vaccine or any other vaccine in the past?			
5. Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-Barre syndrome (a condition that causes paralysis), or other nervous system problem?			
6. Are you 65 years of age or older?			
7. If you answered yes to question #6, have you ever had a pneumococcal, or "pneumonia," vaccination?			
8. Do you smoke OR have a chronic condition (such as asthma or diabetes)?			
9. For women: Are you pregnant or considering becoming pregnant in the next month?			
10. Do you have cancer, leukemia, lymphoma, HIV/AIDS, or any other immune system disorder,t or are you in contact with anyone who has a severely weakened immune system?			
11. Are you currently on home infusions, weekly injections, and/or taking medications such as Remicade®, Enbrel®, Humira®, Kineret®? Please refer to your healthcare provider if unsure about medication history.			
12. Do you take cortisone, prednisone, other steroids, anticancer drugs, or have had radiation treatments?			
13. Are you receiving aspirin therapy or aspirin-containing therapy? (18 years of age and younger only)			
14. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?			

Section C

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, Astrup Drug, Inc., as applicable, to administer the vaccine(s) I have requested above. I understand 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 Vaccine Information Statements on the vaccine(s) I have elected to receive. I also acknowledge I have had a chance to ask questions and that such questions were answered to my satisfaction. I acknowledge I have been advised to remain near the vaccination location for approximately 15 minutes after the administration for observation by the administering healthcare provider. On behalf of myself, my heirs, and personal representatives, I hereby release and hold harmless Astrup Drug, Inc., its staff, agents, employees, successors, divisions, affiliates, subsidiaries, officers, directors, and contractors 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 hereby authorize Astrup Drug, Inc., its employees, agents, and contractors to release any medical or other information relating to these vaccinations to my healthcare professionals, Medicare, Medicaid, or other third party payor necessary to effectuate care or payment and request that payment of authorized benefits be made on my behalf to Astrup Drug, Inc., as applicable. I understand that disclosures of information contemplated herein include information regarding communicable diseases (including HIV), mental health, and drug/alcohol abuse information.

I further acknowledge that I understand the purpose and benefits of my state's immunization and exchange registry, including the Minnesota Data Sharing Law. I understand that immunization information like that pertaining to vaccinations requested by me are reported for both purposes of public health and for coordinating my healthcare by my providers. By my signature herein, I consent to participation in this exchange. I further acknowledge that I may opt out of Minnesota's MIIC program, or request that my records be locked, by contacting the Minnesota Department of Health at 651.201.5207 or by making a MIIC Privacy Setting Change Request at **https://www.health.state.mn.us/people/immunize/miic/privacy/dataprivacy.html** and filing the appropriate form.

I understand that any payment for which I am financially responsible shall be due at the time of the service or, if applicable, when Astrup Drug, Inc., as applicable, invoices me after the service and upon receipt of such invoice.

Signature: _____ **Date:** _____

Section D (HEALTHCARE PROVIDERS ONLY) *The following section is to be completed by the healthcare provider only.*

Immunizer Name (Print): _____ Immunizer Signature: _____ RPh/PharmD/RN/LPN/LVN/NP/PA/MA (circle one)

If applicable, Certified Intern Name (print): _____ Certified Intern Signature: _____

Vaccine	Lot #	Exp Date	Manufacturer	Dosage	Circle Site of Injection	VIS Date	Date PNL Sent	MIIC Reported Date
Inactivated Influenza				0.5 ml	L / R Deltoid IM			
High Dose Influenza				0.5 ml	L / R Deltoid IM			
Quadrivalent Influenza				0.5 ml	L / R Deltoid IM			

[1] Healthcare providers can be an immunization-certified pharmacist or a registered nurse, licensed practical nurse, licensed practical nurse, licensed vocational nurse, nurse practitioner, or physician's assistant.

[2] Sterling Pharmacy is committed to protecting and respecting your privacy. We'll only use your personal information to administer your account and provide the products and services you requested from us. From time to time, we would like to contact you about our products and services, as well as other content that may be of interest to you. For more information, please review the Privacy Policy on our website.

Immunization Insurance Information

Please Print Clearly

Sterling PHARMACY

First Name | MI | Last Name

_____ /_____ /_____
Date of Birth

Note: If you have Medicare, your flu and pneumonia shots will be covered by Medicare Part B (your red, white, and blue card) unless you are enrolled in a Medicare Advantage Plan.

1. Medicare Part B:

ID #

Name on Card (if different from form) | MI | Last Name

2. Medicare Advantage, Medicare Part D, or Commercial Plan:

BIN | PCN

Rx Group | Member ID