

PATIENT: COMPLETE SECTIONS A, B, C



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Vaccine Administration Record (VAR) Informed Consent for Vaccination

Section A Please print clearly.

Form fields for patient information: Home Phone, Date of Birth, Age, Gender, First Name, MI, Last Name, Home Address, City, State, Zip Code, E-mail Address, Primary Care Physician Name, Physician Phone, Physician Address, Medicare Part B Number, Check Requested Vaccine (Flu Shot, Flu Nasal Spray, Pneumonia, Other).

Section B

Table with 3 columns: Question, Yes, No, Don't Know. Questions 1-15 regarding eligibility for ALL VACCINES and LIVE VACCINES.

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 who is at least 14 years of age or older as required by state law; or (iii) the legal guardian of the Patient.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_
Person Receiving Vaccine (or Parent or Guardian, if recipient is a minor)

Section D (PHARMACIST ONLY) The following section is to be completed by the immunizing pharmacist only.

Table for pharmacist completion with columns: Immunizer Name, Intern Name, Vaccine, Lot #, Exp Date, Manufacturer, Dosage, Circle Site of Injection, VIS Date, Date PNL Sent.