Vaccine Administration Record (VAR)

HOMETOWN PHARMACY

SIDE A – FOR PATIENT USE

PATIENT INFORMATION

LAST NAME | **FIRST NAME** | **M.I.** | **GENDER (M/F/O)** | **DATE OF BIRTH (MM/DD/YYYY)**

ADDRESS | **CITY** | **STATE** | **ZIP**

PHONE NUMBER | **EMAIL**

PRIMARY CARE PROVIDER NAME | **EMERGENCY CONTACT NAME** | **EMERGENCY CONTACT PHONE NUMBER**

RACE/ETHNICITY

❑Declined ❑Asian/Pacific Islander ❑Hispanic ❑Multi-racial
❑American Indian/Alaskan Native ❑Black (Not of Hispanic Origin) ❑White (Not of Hispanic Origin) ❑Other:

PAYMENT INFORMATION

❑COMMERCIAL INSURANCE/PART D

Plan Name

Member/Recipient ID #

RX BIN # RX PCN #

Group #

❑MEDICARE PART B

Medicare Number †

Last 4 Digits of SSN*

† Number on the red, white & blue Medicare card.
* For insurance confirmation purposes only.

❑UNINSURED

I do not have any insurance, including but not limited to, Medicare, Medicaid, Private Insurance or any other government-funded benefit plan. In order to track the administration of your vaccine today, please check a box & provide **ONE** of the following ID forms on the line below:

❑Drivers License # / ❑State ID Number / ❑ Social Security #

❑I refuse to provide one of the following ID forms listed above.

VACCINE REQUESTED

❑Influenza (Flu) ❑Hepatitis A ❑Hepatitis A/B ❑HPV ❑Pneumococcal ❑Whooping Cough (Tdap)
❑COVID-19 ❑Hepatitis B ❑Herpes Zoster (Shingles) ❑Meningococcal ❑Tetanus (Td) ❑Other:

PRECAUTIONS & CONTRAINDICATIONS

1. Are you sick today? ❑Yes ❑No
2. Do you have allergies to medications, food or vaccines or vaccine components? ❑Yes ❑No
   (examples: aluminum, eggs, gelatin, lactose, latex, phenol, polyethylene glycol, thimerosal, yeast, etc.)
   If **Yes**, what are you allergic to?
3. Have you ever had a serious reaction after receiving an immunization? ❑Yes ❑No
4. Have you ever fainted or felt dizzy after receiving an immunization? ❑Yes ❑No
5. Are you currently being treated for a long-term health problem? ❑Yes ❑No
   (examples: heart disease, ling disease, asthma, kidney disease, diabetes, anemia or other blood disorder)
6. Are you currently being treated for cancer, leukemia, AIDS or any other immune system problem? ❑Yes ❑No
7. Are you currently taking steroids such as cortisone or prednisone, or anticancer drugs? ❑Yes ❑No
8. Do you have a history of Guillain Barré syndrome? ❑Yes ❑No
9. Have you had a seizure or a brain or nerve problem? ❑Yes ❑No
10. During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin? ❑Yes ❑No
11. **For Women:** Are you pregnant or is there a chance you could become pregnant during the next month? ❑Yes ❑No
12. Have you received any vaccinations in the past 4 weeks? ❑Yes ❑No
    If **Yes**, what vaccine(s)?

ADVERSE REACTIONS & DISCLAIMER

A vaccine, like any medicine, is capable of causing serious problems, such as severe allergic reactions. The risk of any vaccine causing serious harm, or death, is extremely small. Local symptoms may include: slight tenderness, redness, itching or swelling at the site of injection. Systemic symptoms may include: fever, malaise and muscle pain. Other systemic symptoms may occur infrequently. These reactions usually begin 6 to 12 hours after immunization and can persist for a few days. Immediate presumable allergic reactions such as hives, angioedema, allergic asthma or systemic anaphylaxis occur rarely after immunization. These reactions may result from hypersensitive reactions in people with severe egg allergy, and such people should not be given certain vaccines that contain eggs. People with documented immunoglobulin E (IgE)-mediated hypersensitivities to eggs or any other vaccine components, including thimerosal, may also be at increased risk of reactions from immunizations. In the case of a severe reaction such as a high fever, behavior changes or flu-like symptoms that occur after vaccination, see a doctor right away. Signs of an allergic reaction can include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heartbeat, or dizziness within a few minutes to a few hours after the shot.

I have read & will take with me the Vaccine Information Statement (VIS)/EUA about the vaccine. I have had an opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine being adminstered and authorize the administration of the vaccine to me or the person named above for whom I am authorized to make this decision.

PATIENT SIGNATURE **DATE**

PARENT / LEGAL GUARDIAN SIGNATURE **DATE**

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SIDE B – FOR PHARMACY USE ONLY

VACCINE INFORMATION

❑ **Influenza Vaccine:** _____ manufactured by: _____

❑ **COVID-19 Vaccine:** _____ manufactured by: _____

❑ **Adacel®** manufactured by Sanofi
❑ **Boostrix®** manufactured by GSK
❑ **Engerix-B®** manufactured by GSK
❑ **Engerix-B® Pediatric** manufactured by GSK
❑ **Gardasil®9** manufactured by Merck
❑ **Havrix®** manufactured by GSK
❑ **Havrix® Pediatric** manufactured by GSK
❑ **Menactra®** manufactured by Sanofi
❑ **MenQuadfi™** manufactured by Sanofi
❑ **Menveo®** manufactured by GSK
❑ **Pneumovax®23** manufactured by Merck
❑ **Prevnar13™** manufactured by Pfizer
❑ **Recombivax HB®** manufactured by Merck
❑ **Shingrix®** manufactured by GSK
❑ **Tenivac®** manufactured by Sanofi
❑ **Vaqta®** manufactured by Merck
❑ **Vaqta® Pediatric** manufactured by Merck
❑ **Other:** _____

LOT # _____ **EXP. DATE** _____

ADMINISTRATION INFORMATION

SITE OF INJECTION & DOSAGE

ROUTE:	SITE:	SIDE	DOSE
❑ Intramuscular (IM)	❑ Deltoid Muscle	❑ Left	❑ #1
❑ Subcutaneous (SC)	❑ Anterolateral Thigh	❑ Right	❑ #2

OBSERVATION PERIOD

TIME:
❑ 15 Minutes
❑ 30 Minutes

NOTES: _____

ADDITIONAL QUESTIONS

1. Was patient given most recent VIS/EUA? (Version Date: / /) ❑ Yes ❑ No

2. Was the WIR (Wisconsin Immunization Registry) / IZ Record checked prior to immunization? ❑ Yes ❑ No

3. Did the patient bring an immunization record card with them? ❑ Yes ❑ No

4. Did you give them a new immunization record card? ❑ Yes ❑ No

5. Did the patient have an adverse reaction to the vaccine? ❑ Yes ❑ No

If **Yes**, please describe: _____

6. Side A of this form was completed by: ❑ Patient ❑ Caregiver: _____

FORM REVIEWED BY SIGNATURE _____ **DATE** _____

VACCINE ADMINISTRATOR SIGNATURE _____ **DATE** _____

*** Place Rx Sticker Here ***

HOMETOWN PHARMACY

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