DUANE reade™

IMMUNIZATION LOCATION

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

PATIENT: COMPLETE SECTIONS A, B, C

Section A Please print clearly.

Home Phone | Date of Birth | Age | Gender ☐ Male ☐ Female

First Name | MI | Last Name

Home Address | City | State | Zip Code

E-mail Address

Primary Care Physician Name (If known) | Physician Phone

Physician Address | City | State

Medicare Part B Number (if applicable)

Check Requested Vaccine

☐ **Flu Shot** ☐ **Flu Nasal Spray (live)** (ages 2 to 49 only) ☐ **Pneumonia** ☐ **Other** _____

Section B The following questions will help us determine your eligibility to be vaccinated today. For All Vaccines: Please answer questions 1- 9. For Live Vaccines *(e.g. Live Attenuated Influenza Nasal Spray or Zostavax): Please answer questions 1 - 17*		YES	NO	DON'T KNOW
ALL VACCINES	1. Which vaccines are you requesting to have administered today? **Please list all requested vaccines:**			
	2. Do you feel sick today?			
	3. Do you have allergies to medications, food or any vaccine? (Examples: Eggs, Bovine Protein, Gelatin, Gentamicin, Polymyxin, Neomycin, Phenol or Thimerosal) **If yes, please list the allergies:**			
	4. Have you received any vaccinations in the past 4 weeks? **If yes, please list the immunization:**			
	5. Have you ever had a serious reaction to an influenza vaccine or any other vaccine in the past?			
	6. 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?			
	7. Are you 65 years of age or older OR do you smoke OR have a chronic condition (such as asthma or diabetes)?			
	8. If you answered YES to question #7 , have you ever had a pneumococcal, or "Pneumonia," vaccination?			
	9. For women: Are you pregnant or considering becoming pregnant in the next month?			
LIVE VACCINES	10. Do you have cancer, leukemia, lymphoma, HIV/AIDS or any other immune system disorder or are 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 health care provider if unsure about medication history.			
	12. Do you take cortisone, prednisone, other steroids, anticancer drugs or have had radiation treatments?			
	13. Have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin in the past year?			
	14. Are you receiving aspirin therapy or aspirin-containing therapy? (18 years of age and younger only)			
	15. 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?			
	16. If the patient receiving vaccine is under 5 years old, does he/she have a history of asthma or wheezing?			
	17. Does the patient have a nasal condition serious enough to make breathing difficult, such as a very stuffy nose? (for FluMist® only)			

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 9 years of age or older as required by state law; or (iii) the legal guardian of the Patient. Further, I hereby give my consent to the health care provider of Duane Reade 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 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 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 health care provider. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless Duane Reade, its staff, agents, successors, 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 authorize Duane Reade 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 on my behalf to Duane Reade with respect to the vaccine(s) listed above.

Signature: _____ Date: _____

Person Receiving Vaccine (or Parent or Guardian, if recipient is a minor)

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/RN/LPN/LVN/NP (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
Inactivated influenza ☐ -PF				0.5 ml	L / R Deltoid IM		
Pneumococcal polysaccharide				0.5 ml	L / R Deltoid IM		

*Health care providers can be an immunization certified pharmacist or a registered nurse, licensed practical nurse, licensed vocational nurse, nurse practitioner or physician's assistant.