Jeff's Topcare Pharmacy **4901 FM 2920 Rd, Spring, Tx 77388**

Vaccine Administration Record (VAR) **Rx number:**

Informed Consent for Vaccination

Section A *Please PRINT clearly*

Name (Last, First):_____

Date of Birth: _____ Age: _____ Gender: M / F Phone: _____

Home Address: _____ City: _____

State: _____ Zip code: _____ Email address: _____

We will send the vaccination information to your Doctor/ primary care provider using the information below:

Doctor/ primary care provider name_____ Phone: _____

Address: _____ City: _____ Zip: _____

I want to receive the following vaccination(s): _____

Section B The following questions will help us determine your eligibilty to be vaccinated today:

All Vaccines

1. Do you feel Sick today? .....____yes ___No ____Don't know
2. Do you have any health conditions we should know of, such as heart disease, diabetes, or asthma?
   if yes please list:_____.....____yes____No____Don't know
3. Do you have allergies to latex, medications, food or vaccines (examples: eggs, bovine protein, gelatin, gentamicin
   polymixin, neomycin, phenol, yeast, or thimerisol? .....____yes____No____Don't know
   If yes, please list: _____
4. Have you ever had a reaction after receiving a vaccination, including fainting or dizziness.....___Yes___No___Don't know
5. Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-Barrie
   syndrome (a condition that causes paralysis) or other nervous system problems? .....___yes___No__Don't know
6. **For women:** Are you pregnant or considering becoming pregnant in the next month? .....___yes___No___Don't know
7. Have you been diagnosed with or tested positive for COVID-19 in the last 14-days?.....___Yes __No ___Don't know
8. In the last 14 days have you been identified as a close contact to someone with COVIS-19?.....___Yes __No ___Don't know
9. Have you received any vaccinations or skin tests in the past eight weeks? .....___Yes __No ___Don't know
10. Have you ever received the following vaccinations?

___Pneumonia: Date recv'd:_____/ ___Shingles:Date Recv'd _____? ___Whooping Cough(TDaP)Date :_____

11. For COVID-19 vaccine only:Have you been treated with antibody therapy specifically for COVID-19(monoclonal antibodies)

Live Vaccines (chickenpox, flu nasal spray, MMR II, oral typhoid, shingles: fill out this section only if receiving these vaccinations

7. Have you received any vaccinations or skin tests in the past four weeks? .....___yes___NO___Don't know
   If yes, please list_____
8. Do you have a condition that may weaken your immune system (e.g. cancer, leukemia, lymphoma, HIV/AIDS,
   transplany)? .....___yes___no___Don't know
9. Are you currently on home infusions, weekly injections such as Humira, Remicade, or Enbrel?..... ___yes___No___Don't know
   high dose methotrexate, azathioprine, or 6-mercaptopurine, antivirals, anti-cancer drugs or radiation?
10. Are you taking high dose steroid therapy (prednisone>20mg/day for longer than 2 weeks?..... ___yes___No___Don't know
11. Have you received a transfusion of blood or blood products or been given a medication called immune (gamma)
    globulin in the past year? .....___yes___No__Don't know
12. Do you have a history of thymus disease (including myasthenia gravis, DiGeorge syndrome or thymoma), or had
    your thymus removed? (yellowfever vaccine only).....___Yes___No___Don't know
13. Are you currently taking any antibiotics or antimalarial medications? (Oral typhoid only).....___Yes___No___Don't know
14. Do you have a history of thrombocytopenia or thrombocytopenia purpura? (MMR II only).....___Yes___No___Don't know

Patient/Guardian signature: _____ Date: _____

Section C — HEALTHCARE PROVIDER ONLY

Complete BEFORE vaccination administration

1. I have revewed the **Patient Information** and **Screening Questions** .....**Initial Here**_____
2. **This is the vaccine requested** by the patient> .....**Initial Here** _____
3. This vaccine is appropriate for the patient based on the **Age Guidelines** provided by federal and/or state regulations and company policies.....**Initial Here**_____
4. The **Vaccine NDC Matches** the NDC on the bottom of this VAR form and the NDC on the patient leaflet. **(Perform 3-Way NDC match).** .....**Initial Here**_____
5. I have verified the **Expiration Date** is greatyer than today's date and have entered the **Lot # and Expiration Date** in the field below. .....**Initial Here:**_____

Section D

Complete DURING the Patient Interaction

1. I have asked the patient to confirm their **Name, DOB, and Requested Vaccine** and verified it matches the information on the VAR form..... **Initial Here**_____
2. I have reviewed the **Screening Questions** with the patient.....**Initial Here**_____
3. I have reviewed the **VIS** with the patient.....**Initial Here** _____

Section E

Complete AFTER Vaccine administration

Vaccine	NDC	Dosage	Site of adm	Lot#	Exp Date
AFLURIA	33332-0025-03	0.5		AX4603A	05/31/2026
FLUAD	70461002503	0.5		407247	Apr-26

Pharmacist Name: ____JEFF BAEK_____ **Signature:**_____ **Title:** _____RPH _____

Pharmacist Name: ____Mandy Baig_____ _____ **Signature:**_____ **Title:** _____RPH _____

Pharmacist Name: _____ **Signature:**_____ **Title:** _____RPH _____

Other Certified Immunizer Name/ Signature:_____Administration Date: _____

Section F

	Pharmacy Card	Medicare Number:			
Insurance Plan/Plan ID:					
Member/Recipient ID#:					
RX BIN #:					
RX PCN#:					
Rx Group#:					
		Medicare # from your Red/White/Blue Card			

Notes