Vaccine Administration Record (VAR) - Informed Consent for Vaccination

SECTION A

First Name: _____ **Last Name:** _____ **Date of Birth:**_____ **Age:**_____

Gender: Select **Phone Number**_____ **Primary Care Physician:** _____

Address _____ **City** _____ **State** _____ **Zip Code** _____ **Tricare:** No

Immunization(s) to be administered:

- ☐ **Flu**
- ☐ **COVID-19**
- ☐ **Pneumonia**
- ☐ **Shingles**
- ☐ **Tdap (tetanus, diptheria, whooping cough)**
- ☐ **RSV**
- ☐ **Hepatitis A**
- ☐ **Hepatitis B**
- ☐ **Hepatitis A/B**
- ☐ **Other:**

SECTION B *(The following questions will help us determine your eligibility to be vaccinated today).*

1. Are you currently sick with a sore throat, fever, vomiting/diarrhea or have covid?	◯YES	◯NO	◯UNSURE
2. Have you ever had a reaction (dizziness, fainted, anaphylaxis) after an immunization?	◯YES	◯NO	◯UNSURE
3. Do you have an immune system disorder? If yes, please list: _____	◯YES	◯NO	◯UNSURE
4. Do you have allergies to medications, food or vaccines? (Examples: latex, eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast, polysorbate, PEG, or thimerosal)? If yes, please list: _____	◯YES	◯NO	◯UNSURE
5. Have you ever been prescibed an EpiPen? For what indication?	◯YES	◯NO	◯UNSURE
6. Have you received any vaccinations, or skin tests in the past 90 Days?	◯YES	◯NO	◯UNSURE
7. In the past 90 days, have you taken any medications that affect your immune system such as prednisone, other steroids, anticancer medications, radiation, or medications for rheumatoid arthritis, Crohn's disease, psoriasis? If yes, please list what and when:_____	◯YES	◯NO	◯UNSURE
8. Have you ever been diagnosed with a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-Barré syndrome or other nervous system problems?	◯YES	◯NO	◯UNSURE
9. Do you have any heath conditions, such as heart disease, diabetes, or asthma?	◯YES	◯NO	◯UNSURE
10. ***Women Only*** : Are you pregnant or considering becoming pregnant?	◯YES	◯NO	◯UNSURE

SECTION C

I certify that I am: (i) the Patient and at least 18 years of age; or (ii) the legal guardian of the Patient. Further, I hereby give my consent to the healthcare provider of Bell Pharmacy, as applicable, 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/if asked, had explained to me the Vaccine Information Statements (VIS) 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 healthcare provider. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless Bell Pharmacy, as applicable, its staff, agents, successors, divisions, affiliates, subsidiaries, interns/students, 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 acknowledge that: (a) I understand the purposes/benefits of my state's immunization registry ("Registry"); (b) I may, if my state permits, object to Bell Pharmacy disclosing my immunization information to the Registry by providing Bell Pharmacy with a state approved Registry disclosure opt out form (which I may request and obtain from Bell Pharmacy, if permitted by my state); and (c) Unless I provide Bell Pharmacy with an approved opt out form, I have elected to participate in the Registry and consented to Bell Pharmacy reporting my immunization information. I authorize Bell Pharmacy, as applicable, to (i) release my medical or other information, including my communicable disease (including HIV), mental health and drug/alcohol abuse information, to my healthcare professionals, Medicare, Medicaid, or other third party payer as necessary to effectuate care or payment, (ii) submit a claim to my insurer for the above requested items and services, and (iii) request payment of authorized benefits be made on my behalf to Bell Pharmacy, as applicable, with respect to the above requested items and services. I further agree to be fully financially responsible for any co-sharing amounts, including copays, coinsurance, and deductibles, for the requested items and services as well as for any requested items and services not covered by my insurance benefits. I understand that any payment for which I am financially responsible is due at the time of service or, if Bell Pharmacy invoices me after the time of service, upon receipt of such invoice. Your signature or that of your responsible party, acknowledges receipt of administration of vaccine on the administration date for any and all third party document completion requirements. I further authorize the release of any and all information to payers and employers and responsible parties rendering payment of any immunization services. Patient or caregiver is responsible for updating primary care provider. Your signature also gives POA when manually billing your major medical insurance authorizing payment made to above provider.

Patient/Caregiver/POA Signature: X:_____ **Date:** _____ **Circle: Right or Left Arm**

Dose: _____

SECTION D **HEALTHCARE PROVIDER COMPLETION ONLY**

Complete **BEFORE** vaccine administration

Additional Notes and/or Questions via Pharmacist Documented:_____

Authorizing physician standing order (Prescription) administered immunization(s).

Complete **AFTER** vaccine administration

Place Back Tag here	

IMMUNIZER NAME (PRINT) _____ SIGNATURE:_____

ADMINISTRATION DATE:_____ DATE VIS GIVEN to Patient/Caregiver_____

❑ Bell 1	❑ Bell 2	❑ Bell 3	❑ Bell 4	❑ Bell 5
3535 Central Ave. St. Petersburg, FL 33713 Ph: 813-689-2273	8702 Hunters Lake Dr. Suite 140 Tampa FL 33647 Ph: 813-803-3399	1246 Ray Charles Blvd, Tampa FL 33602 Ph: 813-694-7020	38008 North Ave. Zephyrhills FL 33542 Ph: 813-780-7216	14100 US Hwy 19 N #129, Clearwater, FL 33764 Ph: 727-390-2620