Walgreens

Store Number: _____ Rx Number: _____

Store Address: _____

_____

# Vaccine Administration Record (VAR) - Informed Consent for Vaccination*

## Section A

***Complete a separate VAR for each administered vaccine***

**Patient First Name:** _____ **Patient Last Name:** _____

**Date of Birth:** _____ **Age:** _____ **Gender:** ☐ Female ☐ Male **Phone Number:** _____

**Home Address:** _____

**City:** _____ **State:** _____ **Zip:** _____

**Email Address:** _____

**Walgreens will send immunization information from this visit to your doctor/primary care provider using the contact information provided below.**

**Doctor/Primary Care Provider Name:** _____ **Phone Number:** _____

**Address:** _____

**City:** _____ **State:** _____ **Zip:** _____

I want **to receive the following immunization(s):** _____

## Section B

***The following questions will help us determine your eligibility to be vaccinated today.***

**All Vaccines**

| | | |
|---|---|---|
| 1 | Do you feel sick today? | ☐ Yes ☐ No ☐ Don't know |
| 2 | Do you have any health conditions such as: heart disease, diabetes or asthma?<br>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, polymyxin, neomycin, phenol, yeast, or thimerosal)?<br>If yes, please list: _____ | ☐ Yes ☐ No ☐ Don't know |
| 4 | Have you ever had a reaction after receiving an immunization including fainting or feeling dizzy? | ☐ 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-Barré Syndrome (a condition that causes paralysis) or other nervous system problem? | ☐ Yes ☐ No ☐ Don't know |
| 6 | For women: Are you pregnant or considering becoming pregnant in the next month? | ☐ Yes ☐ No ☐ Don't know |

**Live vaccines (Chicken pox, flu nasal spray, MMR®, oral typhoid, shingles, Yellow fever)**
Only answer these questions if you are receiving any immunizations listed above.

| | | |
|---|---|---|
| 7 | Have you received any vaccinations or skin tests in the past four weeks?<br>If yes, please list: _____ | ☐ Yes ☐ No ☐ Don't know |
| 8 | Do you have a condition that may weaken your immune system (e.g., cancer, leukemia, lymphoma, HIV/AIDS, transplant)? | ☐ Yes ☐ No ☐ Don't know |
| 9 | Are you currently on home infusions, weekly injections such as Humira® (adalimumab), Remicade® (infliximab) and Enbrel® (etanercept), high-dose methotrexate, azathioprine or 6-mercaptopurine, antivirals, anticancer drugs or radiation treatments? | ☐ Yes ☐ No ☐ Don't know |
| 10 | Are you currently taking high dose steroid therapy (prednisone > 20mg/day or equivalent) for longer than 2 weeks? | ☐ Yes ☐ No ☐ Don't know |
| 11 | Have you received a transfusion of blood, 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? (Yellow fever 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® only) | ☐ Yes ☐ No ☐ Don't know |

**Flu nasal spray (FluMist® Quadrivalent)**

| | | |
|---|---|---|
| 15 | Are you receiving aspirin therapy or aspirin-containing therapy? (18 years of age and younger only) | ☐ Yes ☐ No ☐ Don't know |
| 16 | Do you have a nasal condition serious enough to make breathing difficult, such as a very stuffy nose? (For FluMist® only) | ☐ Yes ☐ No ☐ Don't know |

## Section C

I certify that I am: (a) the patient and at least 18 years of age; (b) the parent or legal guardian of the minor patient; or (c) the legal guardian of the patient. Further, I hereby give my consent to the healthcare provider of Walgreens, Duane Reade, Take Care Health Services, or DR Walk-in Medical Care, as applicable (each an "applicable Provider"), 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 healthcare provider. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless the applicable Provider, 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 acknowledge that: (a) I understand the purposes/benefits of my state's immunization registry ("State Registry") and my state's health information exchange ("State HIE"); and (b) the applicable Provider may disclose my immunization information to the State Registry, to the State HIE, or through the State HIE, to the State Registry, for purposes of public health reporting or to my health care providers enrolled in the State Registry and/or State HIE for purposes of care coordination. I acknowledge that, depending upon my state's law, I may prevent, by using a state-approved opt-out form or, as permitted by my state law, an opt-out form ("Opt-Out Form") furnished by the applicable Provider: (a) the disclosure of my immunization information by the applicable Provider to the State HIE and/or State Registry; or (b) the State HIE and/or State Registry from sharing my immunization information with any of my other healthcare providers enrolled in the State Registry and/or State HIE. The applicable Provider will, if my state permits, provide me with an Opt-Out Form. I understand that, depending on my state's law, I may need to specifically consent, and to the extent required by my state's law, by signing below, I hereby do consent to the applicable Provider reporting my immunization information to the State HIE, or through the State HIE and/or State Registry to the entities and for the purposes described in this Informed Consent form. Unless I provide the applicable Provider with a signed Opt-Out Form, I understand that my consent will remain in effect until I withdraw my permission and that I may withdraw my consent by providing a completed Opt-Out Form to the applicable Provider and/or my State HIE, as applicable. I understand that even if I do not consent or if I withdraw my consent, my state's laws may permit certain disclosures of my immunization information to or through the State HIE as required or permitted by law. I also authorize the applicable Provider to disclose my, or my child's (or unemancipated minor for whom I am authorized to act as guardian or in loco parentis) proof of immunization to the school where I am, or my child (or unemancipated minor for whom I am authorized to act as guardian or in loco parentis) is, a student or prospective student. I further authorize the applicable Provider to (a) release my medical or other information, including my communicable disease (including HIV), mental health and drug/alcohol abuse information, to, or through, the State HIE to my healthcare professionals, Medicare, Medicaid, or other third-party payer as necessary to effectuate care or payment, (b) submit a claim to my insurer for the above requested items and services, and (c) request payment of authorized benefits be made on my behalf to the applicable Provider with respect to the above requested items and services. I further agree to be fully financially responsible for any cost 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, the applicable Provider invoices me after the time of service, upon receipt of such invoice.

**Patient Signature:** _____ **Date:** _____

(Parent or Guardian, if minor)

*Healthcare providers can be an immunization-certified pharmacist or a registered nurse, licensed practical nurse, licensed vocational nurse, nurse practitioner, physician or physician's assistant.**Patient care services at Healthcare Clinic at select Walgreens provided by Take Care Health Services, an independently owned professional corporation whose licensed healthcare professionals are not employed by or agents of Walgreen Co. or its subsidiaries, including Take Care Health Systems, LLC. Walgreen Co. and its subsidiary companies provide management services to provider practices, in-store clinics and worksite health and wellness centers.

*Healthcare Provider Only*

## Section D - Complete BEFORE Vaccine Administration

1. I have reviewed 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 this patient based on the **Age Guidelines** provided by federal, 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 greater than today's date and have entered the **Lot # and Expiration Date** in the field below. Initial here: _____

Lot #: _____

Expiration Date: _____

**Note:** For Zostavax®, MMR® II, Varivax®, YF-Vax®, Menveo®, Imovax®, and Rabavert®, ensure the vaccine is reconstituted following the package insert's instructions.

## Section E - 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 F - Complete AFTER Vaccine Administration

| Vaccine | NDC | Manufacturer | Dosage | Site Of Administration | VIS published date |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

**Immunizer Name (print):** _____ **Immunizer Signature:** _____ **Title:** _____

**If applicable, Intern's Name (print):** _____ **Administration Date:** _____ **Date VIS given to patient:** _____

**Reminder:**

1. Update the patient record with any new allergy, health condition or primary care provider information.
2. Enter vaccine lot #, expiration date, and site of administration, and then scan VAR form into the patient record.

# INSURANCE INFORMATION FORM

Please complete this form ahead of time. The information can be found on your prescription insurance card or Medicare card.

**Name (PLEASE PRINT First & Last): _____**

**DOB (Date of Birth): _____**

**MEMBER ID: _____**

**RX PCN: _____**

**RX BIN: _____**

**RX GROUP: _____**

**Medicare ID/Number (red, white, and blue card): _____**

☐ **I do not have insurance** (please fill out Name and DOB)

## HOLD HARMLESS AGREEMENT

This Hold Harmless Agreement ("Agreement") is entered into as of the date set forth below by the undersigned (the "Participant"), on behalf of her/himself and on behalf of, and as legal guardian of, the undernamed child or children (individually and collectively, the "Child"), in favor of The Roman Catholic Church of the Diocese of Baton Rouge and the Congregation of Most Blessed Sacrament Catholic Church , who hereby agree as follows:

1. Walgreen Co. or its affiliates ("Walgreens") will be available on-site at the Church's facilities at 15615 Jefferson Highway, Baton Rouge, LA 70817 to provide the annual influenza vaccine (the "Flu Vaccine") to those adults and children who have not yet been vaccinated this flu season.

2. The Participant understands that his/her or the Child's health care provider, as applicable, may administer the Flu Vaccine. Nonetheless, the Participant requests that Walgreens administer the Flu Vaccine to the Child and/or the Participant, at the Participant's sole discretion.

3. The Participant has read the notices, information sheets and other disclosures provided by Walgreens and fully comprehends and understands the risks associated with the Flu Vaccine. Contemporaneous herewith, the Participant has completed and signed the consent form and consents to Walgreens administering the Flu Vaccine to the Participant and/or Child, in the Participant's sole discretion.

4. Participant assumes all responsibility and sole liability for any claims or actions based upon, or arising out of, injuries, including death, to persons, or damage to or destruction of property, sustained or alleged to have been sustained in connection with or arising out of, or incidental to, or in any way connected with Walgreens' administration of the Flu Vaccine to the Participant and/or the Child, regardless of whether such claims or actions are founded in whole or part on the alleged negligence or other fault of the Diocese, Church, or any of its or their respective affiliates, officers, directors, agents, clergy, members, parishioners, invitees, officials, contractors, employees or representatives (each, an "Indemnified Party", collectively, the "Indemnified Parties"), or their conduct or status which might subject them to strict liability. Participant agrees to, and does hereby, protect, defend, indemnify and hold harmless the Indemnified Parties in respect of any such matters and agrees to defend any claim or suit or action brought against any Indemnified Party and to pay all damages, losses, costs and expenses of every kind and description, including reasonable attorneys' fees incurred by any Indemnified Party, as a result of the claim or institution of any suit or action or the defense thereof, as well as any judgments or settlements therein or thereof.

5. This Agreement and the legal relations between the parties to this Agreement will be governed by and construed in accordance with the laws of the State of Louisiana, without regard to the conflicts of law rules thereof. If any provision, clause or part of this Agreement, or the application thereof under certain circumstances, is held invalid, the remainder of this Agreement, or the application of such provision, clause or part under other circumstances, shall not be affected thereby.

Participant is entering into this Agreement, as of the date set forth below, individually and on behalf of:

Name of Child(ren):_____

Signature of Participant:_____
Printed Name of Participant:_____
Date:_____