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

MEDICAP PHARMACY®

SECTION A *(Please print clearly.)*

First name:_____ **Last name:**_____

Date of birth:_____ **Age:**_____ **Gender:** ☐Female ☐Male **Phone:**_____

Home address:_____ **City:**_____

State:_____ **ZIP code:**_____ **Email address:**_____

Medicap Pharmacy can offer influenza vaccinations for persons 6 years of age or older and all other vaccines to persons 13 years and older. All vaccines given at Medicap Pharmacy will be entered into the Minnesota Immunization Information Connection so that it may be accessed by the MN Department of Health and other healthcare providers.

Vaccine Requested:

☐Flu ☐Pneumonococcal ☐Shingles ☐Tdap ☐MMR ☐HepA ☐HepB ☐Meningococcal ☐Varicella ☐HPV ☐Other

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
2. Do you have a chronic condition or long term health problem? *Examples: heart disease, lung disease, asthma, kidney disease, diabetes, anemia, other blood disorders, or are you a smoker?*	☐Yes ☐No
3. Do you have allergies to latex, medications, food or vaccines? *Examples: eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal?* If yes, please list: _____	☐Yes ☐No
4. Have you ever had a reaction after receiving an immunization, including fainting or feeling dizzy?	☐Yes ☐No
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
6. Are you currently pregnant, considering becoming pregnant in the next month, or breast-feeding?	☐Yes ☐No
Live vaccines (chickenpox, flu nasal spray, MMR® II, oral typhoid, shingles) 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? If yes, please list: _____	☐Yes ☐No
8. Do you have a condition that may weaken your immune system (e.g., cancer, leukemia, lymphoma, HIV/AIDS, transplant)?	☐Yes ☐No
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
10. Are you currently taking high-dose steroid therapy (prednisone > 20mg/day or equivalent) for longer than 2 weeks?	☐Yes ☐No
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
12. Are you currently taking any antibiotics or antimalarial medications? (Oral typhoid only)	☐Yes ☐No
13. Do you have a history of thrombocytopenia or thrombocytopenia purpura? (MMR® II only)	☐Yes ☐No
Flu nasal spray (FluMist® Quadrivalent)	
14. Are you receiving asprin therapy or asprin-containing therapy? (18 years of age and younger only)	☐Yes ☐No
15. Do you have a nasal condition serious enough to make breathing difficult, such as a very stuffy nose? (For FluMist® only)	☐Yes ☐No

SECTION C *Please read the section below carefully and sign and date acknowledging that you understand and agree.*

I hereby give my consent to Medicap, as applicable, to administer the vaccination(s) I have requested above. I understand the benefits and risks of receiving this vaccination and have received, read and/or had explained to me the Vaccine Information Statement on the vaccine(s) I have elected to receive. I acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. I acknowledge that I have been advised to remain near the vaccination location for approximately 20 minutes after administration for observation by the administering healthcare provider. On behalf of myself, my heirs, and personal representatives, I fully release and discharge Medicap, its staff, and employees from any and all liabilities or claims whether known or unknown arising in any way related to the administration of the vaccine(s) listed above. **Initials:** _____

I understand the purposes/benefits of my state's immunization registry and acknowledge that, depending upon my state law, I may prevent disclosure of my immunization to the state registry with a signed Opt-Out. **Initials:** _____

I am aware an immunization certified student pharmacist might be administering this vaccination. **Initials:** _____

Patient signature: _____ **Date:** _____

(Parent or guardian, if minor)