Vaccine Administration Record (VAR)

HOMETOWN PHARMACY

SIDE A - FOR PATIENT USE

PATIENT INFORMATION

LAST NAME | FIRST NAME | M.I. | GENDER (M/F) | BIRTH DATE (MM/DD/YYYY)

ADDRESS | CITY | STATE | ZIP

PHONE NUMBER | EMAIL

OPT. FOR NOTIFICATION OF VACCINE AVAILABILITY & OFFERS?
❑Yes Please Notify Me ❑No Thank You

PRIMARY CARE PHYSICIAN | FACILITY OF PRIMARY CARE PHYSICIAN | PHYSICIANS PHONE OR FAX

YOUR SOCIAL SECURITY NUMBER

YOUR SSN WILL NOT BE SHARED WITH ANYONE. IT IS ONLY USED TO POST YOUR IMMUNIZATION ON THE WI IMMUNIZATION REGISTRY (WIR) SO YOUR HEALTH CARE PROVIDER CAN SEE YOUR VACCINE INFORMATION.

PAYMENT INFORMATION

❑ **CASH**

❑ **PART D / COMMERCIAL INSURANCE** GROUP#

❑ **MEDICARE #** ID # | BIN# | PCN#

VACCINE REQUESTED

❑Influenza (Flu) ❑Hepatitis B ❑Meningococcal ❑Tetanus (Td) ❑Zoster (Shingles)
❑Hepatitis A ❑HPV ❑Pneumococcal ❑Whooping Cough (Tdap) ❑Other: _____

PRECAUTIONS & CONTRAINDICATIONS

1. Are you sick today? ❑Yes ❑No
2. Do you have allergies to medications, food or vaccines *(ex: aluminum, eggs, gelatin, lactose latex, phenol, thimerosal yeast etc.)* ❑Yes ❑No
   If yes what are you allergic to? _____
3. Have you ever had a serious reaction after receiving an immunization? ❑Yes ❑No
4. Have you ever fainted or felt dizzy after receiving an immunization? ❑Yes ❑No
5. Are you currently being treated for a long-term health problem such as heart disease, lung disease, asthma, kidney disease, diabetes, anemia or other blood disorder? ❑Yes ❑No
6. Are you currently being treated for cancer, leukemia, AIDS or any other immune system problem? ❑Yes ❑No
7. Are you currently taking steroids such as cortisone or prednisone, or anticancer drugs? ❑Yes ❑No
8. Do you have a history of Guillain Barré syndrome? ❑Yes ❑No
9. Have you had a seizure or a brain or nerve problem? ❑Yes ❑No
10. During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin? ❑Yes ❑No
11. For women: Are you pregnant or is there a chance you could become pregnant during the next month? ❑Yes ❑No
12. Have you received any vaccinations in the past 4 weeks? ❑Yes ❑No
    If yes, what vaccine(s)? _____
13. Are you allergic to eggs? ❑Yes ❑No
14. Are you allergic to latex? ❑Yes ❑No

ADVERSE REACTIONS

A vaccine, like any medicine, is capable of causing serious problems, such as severe allergic reactions. The risk of any vaccine causing serious harm, or death, is extremely small. Local symptoms may include: slight tenderness, redness, itching or swelling at the site of injection. Systemic symptoms may include: fever, malaise and muscle pain. Other systemic symptoms may occur infrequently. These reactions usually begin 6 to 12 hours after immunization and can persist for a few days. Immediate presumable allergic reactions such as hives, angioedema, allergic asthma or systemic anaphylaxis occur rarely after immunization. These reactions may result from hypersensitive reactions in people with severe egg allergy, and such people should not be given certain vaccines that contain eggs. People with documented immunoglobulin E (IgE)-mediated hypersensitivities to eggs or any other vaccine components, including thimerosal, may also be at increased risk of reactions from immunizations. In the case of a severe reaction such as a high fever, behavior changes or flu-like symptoms that occur after vaccination, see a doctor right away. Signs of an allergic reaction can include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heartbeat, or dizziness within a few minutes to a few hours after the shot.

I have read and will take with me the Vaccine Information Statement (VIS) about the vaccine. I have had an opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine being adminstered and authorize the administration of the vaccine to me or the person named above for whom I am authorized to make this decision.

SIGNATURE DATE