BEHAVIORAL HEALTH OF ROCKY TOP

Vaccine Administration Record (VAR)
Informed Consent for Vaccination

SECTION A-1

First Name:_____ Last Name:_____

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

Pharmacy: Behavioral Health of Rocky Top Address:_____

City:_____ State:_____ Zipcode:_____ Email Address:_____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American ☐ White ☐ Other Race ☐ Unknown ☐ Unable to report due to policy/law

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ethnicity ☐ Unable to report due to policy/law

I want to receive the following vaccination(s): COVID-19 Vaccination Patient Type: ☐ Resident ☐ Staff Member

SECTION A-2 I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient; or (c) a person authorized to consent on behalf of the patient where the patient is not otherwise competent or unable to consent for themselves. Further, I hereby give my consent to Behavioral Health Pharmacy Services and the licensed healthcare professional administering the vaccine, 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 EUA Fact Sheet 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 that the patient should remain near the vaccination location for observation for approximately 15 minutes after administration. On behalf of the patient, the patient's heirs and personal representatives, I hereby release and hold harmless each 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 vaccination registry ("State Registry") and my state's health information exchange ("State HIE"); and (b) the applicable Provider may disclose my vaccination information to the State Registry, to the State HIE, or through the State HIE to the State Registry, or to any state or federal governmental agencies or authorities ("Government Agencies"), such as state, county, or local Departments of Health or the federal Department of Health and Human Services, the Center for Disease Control and Prevention, or their respective designees as may be required by law, for purposes of public health reporting, or to my healthcare 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 vaccination 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 vaccination 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 vaccination information to the Government Agencies, 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 or federal law may permit certain disclosures of my vaccination information to or through the State HIE or to Government Agencies as required or permitted by law. I further authorize the applicable Provider to: (a) release my medical or other information, including any communicable disease (including HIV), and mental health information, to, or through, the State HIE or Government Agencies 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, if the applicable Provider invoices me after the time of service, upon receipt of such invoice. Walgreens or its affiliates may contact you, including by autodialed and prerecorded calls and texts, at any time using the contact information provided in your patient record regarding health and safety matters, such as vaccine reminders, regardless of whether you have opted out of being contacted.

Print Name:_____ Patient/Authorized person signature:_____ Date:_____

SECTION B-1 SCREENING QUESTIONS. The following questions will help us determine your eligibility to be vaccinated today.

1. Do you feel sick today?	☐Yes ☐ No ☐ I don't know
2. Have you been treated with antibody therapy for COVID-19 (monoclonal antibodies or convalescent plasma)?	☐Yes ☐ No ☐ I don't know
3. Do you have or have you had COVID-19?	☐Yes ☐ No ☐ I don't know
4. Do you have any Chronic Health Conditions such as Cancer, Chronic Kidney Disease, Immunocompromised, Chronic Lung Disease, Obesity, Sickle Cell Disease, Diabetes, Heart Disease? If yes, please list: _____	☐Yes ☐ No ☐ I don't know
5. Do you have allergies to latex, medications, food or vaccines (examples: eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal)? Do you have a history of anaphylaxis or allergies to anything other than vaccines (food, latex, polyethylene glycol, etc). If yes, please list: _____	☐Yes ☐ No ☐ I don't know
6. Have you ever had a reaction after receiving a vaccination or injectable therapy, including fainting or feeling dizzy?	☐Yes ☐ No ☐ I don't know
7. 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 ☐ I don't know
8. Have you received any vaccines in the last 2-8 weeks? If so, what and when? _____	☐Yes ☐ No ☐ I don't know
9. **For women:** Are you pregnant or considering becoming pregnant in the next month?	☐Yes ☐ No ☐ I don't know

SECTION B-2 I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient or representative of; or (c) a representative of the LTCF and, based upon clinical observation, have sufficient knowledge of the patient's condition to answer the Screening Questions. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.

Patient/LTCF Representative: _____ **Date:** _____

SECTION C INSURANCE – PATIENT OR AUTHORIZED PERSON TO COMPLETE

	Pharmacy Card	Medical Card
Insurance Plan/Plan ID:		
Member/Recipient ID #:		
RX BIN:		N/A
RX PCN:		N/A
Group Number:		

Medicare	Medicare Part B
Medicare Number*:	
Last 4 Digits of SSN**:	

*Number on the red, white, and blue Medicare card
** For insurance confirmation purposes only

If uninsured: I attest that I do not have any medical or pharmacy insurance. ☐ Yes

Drivers License/State ID Number*: (circle one)	Issuance State:

*For verification and coverage Initial: _____

Is the patient the cardholder? ☐ Yes ☐ No ☐ I don't know

If no, please provide cardholders name, date of birth (MM/DD/YYY) and relationship: _____

Healthcare Provider Only: Individual refused to provide insurance information when I attempted to obtain the insurance information from the individual. ☐ Yes

SECTION D HEALTHCARE PROVIDER ONLY

Complete **BEFORE** administration

1. I have reviewed the **Patient Information** and **Screening Questions**. Initial: _____

2. I have verified that this is the **vaccine requested** by the patient.

3. This vaccine is appropriate for this patient based on the **Age Guidelines and Other Guidelines** provided by federal and/or state regulations and company policies. Initial: _____

   3a. Does this patient have a high-risk medical condition? Initial: _____
   If yes, please list medical condition(s): _____

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: _____

5. I have verified the Expiration Date is greater than today's date and have entered the Lot # and Expiration Date in the section F below Initial: _____

SECTION E Complete DURING the patient interaction

1. I confirm(ed) the patient's **Name, DOB, and requested vaccine**, and verified it matches the information on the VAR form. Initial: _____

2. I have reviewed he **Screening Questions** and answers. Initial: _____

3. I provided a **EUA Fact Sheet** to the patient or LTCF representative. Initial: _____

SECTION F

Complete AFTER the vaccine administration

Vaccine	NDC	Manufacturer	Dosage	☐ Dose 1	Site of Administration	EUA Fact Sheet Published Date
				☐ Dose 2		

Clinician's name (print): _____ **Clinician's signature:** _____ **Title:** _____
If applicable, intern/tech name (print): _____ **Administration date:** _____ **Date EUA Fact Sheet given to patient:** _____

COVID-19 VACCINE LOT # _____ **COVID-19 EXPIRATION DATE** _____
DILUENT LOT# _____ **DILUENT EXPIRATION DATE** _____

1. Update the patient's record with any new allergy, health condition or primary care provider information.

2. Enter vaccine lot #, expiration date and site of administration, then scan the VAR form into the patient's record.

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