COVID-19 Vaccine Administration Record (VAR) Informed Consent

PATIENT/CAREGIVER: COMPLETE SECTIONS A, B, C

SECTION A *(Please print clearly.)*

First Name:____________________**Last Name:**________________________**Date of Birth:**___________**Gender:**__________

Medication Allergies: ☐ **None** ☐ **Yes, please list:** ____

Race (select one or more) ☐ Native American or Alaska Native ☐ Asian ☐ Black or African-American ☐ White
☐ Native Hawaiian or other Pacific Islander ☐ Other

Ethnicity (select one or more) ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Phone Number (Home or Mobile):_______________________ **Email Address:** ____________________________________

Home Address:___________________________________**City:**____________________**State:**______**ZIP Code:**___________

Doctor/Primary Care Provider Name:___________________________________ ☐ I do not have a primary care provider

Address:___________________________________ **City:**____________________ **State:**_____**Phone Number:**___________

Pharmacy Staff: Utilize Genoa COVID vaccine insurance collection form to obtain administration billing information. COVID vaccines are provided at no cost to individuals living in the US

SECTION B

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. **If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated.** It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	**No**	**Don't know**
1. Are you feeling sick today?			
2. Have you received a dose of COVID-19 vaccine?			
If yes, which vaccine product did you receive? ☐ Pfizer ☐ Moderna ☐ Another product _____________			
3. Have you ever had an allergic reaction to: *This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)*			
• A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures			
• Polysorbate, which is found in some vaccine, film coated tables, and i.v. steroids			
• A previous dose of COVID-19 vaccine			
4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? *This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.*			
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? *This would include food, pet, environmental, or oral medication allergies.*			

CHECK ALL THAT APPLY TO YOU

- ☐ Am female between ages of 18 and 49 years old
- ☐ Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies
- ☐ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum
- ☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
- ☐ Have a weakened immune system (i.e. HIV infection, cancer)
- ☐ Take immunosuppressive drugs or therapies
- ☐ Have a bleeding disorder
- ☐ Take a blood thinner
- ☐ Have a history of heparin-induced thrombocytopenia (HIT)
- ☐ Am currently pregnant or breastfeeding
- ☐ Have received dermal fillers
- ☐ Am a male between ages 12 and 29 years old
- ☐ Have a history of myocarditis or pericarditis

SECTION C

I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian or authorized representative of the patient; or (c) a representative of a facility in which the patient resides and, based upon clinical observation, have sufficient knowledge of the patient's condition to answer the screening questions provided above.

1. **Pharmacy Contact**.
   By providing my telephone number to Genoa Healthcare on this consent form, I agree to receive pharmacy contact related to my health care and to any follow-up appointments for required multiple-dose COVID-19 vaccine regimens from Genoa Healthcare and its affiliates.
2. **Consent to Receive Vaccines from a Genoa Pharmacist**.
   I hereby give my consent to the healthcare provider of Genoa, as applicable, to administer the COVID-19 vaccine that I have requested. I understand and acknowledge that if I receive the COVID-19 vaccine, it may be administered in two separate doses given at least three weeks apart. I understand that it is not possible to predict all possible side effects or complications associated with receiving the COVID-19 vaccine. I understand the risks and benefits associated with the COVID-19 vaccine and have received, read and/or had explained to me the Vaccine Information Statements on the COVID-19 vaccine 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.
3. **Limitation of Liability**.
   On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless Genoa, as applicable, 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 COVID-19 vaccine.
4. **Disclosure of Records**.
   I understand that Genoa may be required to or may voluntarily disclose my immunization information to any applicable state or federal immunization registry for the purpose of public health reporting, or to my healthcare providers for the purpose of care coordination. I authorize Genoa, as applicable, to 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.
5. **HIPAA Acknowledgement**.
   By signing below, I acknowledge that I have a received a copy of Genoa's currently effective Notice of Privacy Practices, which sets forth the types of uses and disclosures of my personally identifiable health information that Genoa is permitted to make.
6. **Billing and Payment**.
   I authorize Genoa to submit a claim to my insurer for administering the COVID-19 vaccine.
7. **Patient Acknowledgement**.
   I represent that I have read and fully understood the contents above, and I have freely and voluntarily signed this consent form. In addition, if I am signing on behalf of the patient, I certify that I am: (a) legally authorized to provide the required consents on behalf of the patient; or (b) facility personnel that has received verbal consent from the patient's legal guardian or authorized representative, ________________________________ (*name of the patient's legal guardian or authorized representative*), to sign this VAR on behalf of the patient.

Printed Name: ___________________________________ **Signature:** ___________________________________ **Date:** _________________

(Patient, guardian, authorized representative, or facility personnel verbally authorized to sign)

SECTION D **HEALTHCARE PROVIDER ONLY**

Complete BEFORE vaccine administration

Vaccine	Route	Dosage: Approved Ages	Lot #	Expiration Date
COVID-19 (SARS-CoV-2)	Intramuscular	Moderna (≥ 18 years): 0.5 mL		
		Pfizer-BioNTech (≥ 12 years): 0.3 mL		
		Janssen/J&J (≥ 18 years): 0.5 mL		

For any vaccine note listed, write in vaccine type/name, route, dose per approved age, lot # and expiration date

	Immunizer Initials
I have verified the vaccine that the patient requested meets state, age and vaccine restrictions	
I have verified the requested vaccine is the same as the product prepared	
I have verified the vaccine is within the expiration date and beyond use date/time	
I have reconstituted the vaccine following the package insert's instructions	

Complete AFTER vaccine administration

Vaccine	Manufacturer/ NDC # (Circle one)	Dosage (circle one)	Site of Injection (circle side)	VIS/EUA Published Date
COVID-19	Moderna/80777-0273-10	0.5 mL	L / R Deltoid	
	Pfizer/59267-1000-01	0.3 mL		
	Janssen/J&J/59676-580-05	0.5 mL		

Administration Date:___________ **Date VIS/EUA Given to Patient:** __________ **Immunizer Signature:** ___________________________________

Immunizer Name (print):____ **Title:** ___________________________________

If applicable, Intern or Technician name (print): ___________________________ **If applicable, PCP Notified (Date/Time):**_____________________