Documented in FLSHOTS by ___ on _____

NSU NOVA SOUTHEASTERN UNIVERSITY Clinic Pharmacy

DEPARTMENT OF PHARMACY SERVICES
3200 SOUTH UNIVERSITY DRIVE DAVIE, FL. 33328 PHONE: 954-262-4550 FAX: 954-262-3865

Vaccine Administration Record (VAR) Informed Consent for Immunizing Pharmacists

Section A Home Phone:	Date of Birth	Age	Gender
First Name	Middle	Last Name	
Home Address	City	State	Zip Code
Primary Care Physician Name (If known)	Physician Phone		
Physician Address	City	State	

Section B *The following questions will help us determine your eligibility to be vaccinated today. For All Vaccines: Please answer questions: **1-12**. For Live Vaccines (e.g. Shingles): Please answer questions **1-16**.*	YES	NO	DON'T KNOW
ALL VACCINES			
1. Which vaccines are you requesting to have administered today? Please check all requested vaccination: **Flu Shot** ☐ **Pneumonia** ☐ **Shingles** ☐ **Meningitis** ☐			
2. Do you feel sick today?	☐	☐	☐
3. Do you have allergies to medications, food or vaccines? (Examples: Eggs, Bovine Protein, Gelatin, Neomycin) **If yes, please list the allergies:**	☐	☐	☐
4. Have you received any vaccinations in the past 4 weeks? **If yes, please list the vaccination:** _____	☐	☐	☐
5. Have you ever had a serious reaction to an influenza vaccine or any other vaccine in the past?	☐	☐	☐
6. Have you ever had a seizure disorder for which you are on a seizure medication(s), a brain disorder, Guillain-Barre Syndrome (a condition that causes paralysis) or other nervous system problem?	☐	☐	☐
7. Are you 65 years of age or older?	☐	☐	☐
8. Do you smoke?	☐	☐	☐
9. Do you have a chronic condition or longer term health problem? **If yes, please check all that apply.** Anemia ☐ Asthma ☐ Diabetes ☐ Heart disease ☐ Kidney disease ☐ Liver disease ☐ Lung disease ☐ Other ☐ _____	☐	☐	☐
10.If you answered YES to questions # 7, 8, or 9, have you ever had a pneumonia vaccination?	☐	☐	☐
11.Are you a health care worker?	☐	☐	☐
12.For women: Are you pregnant or considering becoming pregnant in the next month?	☐	☐	☐
LIVE VACCINES			
	___		DON'T KNOW
13.Do you have cancer, leukemia, lymphoma, HIV/AIDS or any other immune system disorder or are you in contact with anyone who has a severely weakened immune system?	☐	☐	☐
14.Are you currently on home infusions, weekly injections and/or taking medications as Remicade®, Enbrel®, Humira®, or Kineret®?	☐	☐	☐
15.Do you take cortisone, prednisone, other steroids, anticancer drugs or have you had radiation treatments?	☐	☐	☐
16.Have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin in the past year?	☐	☐	☐
17. Are you currently taking acyclovir (Zovirax), valacyclovir (Valtrex), or famciclovir (Famvir)?	☐	☐	☐

Section C I certify that I am the Patient and at least 18 years of age. Further, I hereby give my consent to the immunizing pharmacist of NSU Clinic Pharmacy 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 have acknowledged that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation by the immunizing pharmacist. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless NSU Clinic Pharmacy, 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 vaccine(s) listed above. **I further agree to be fully financially responsible for any co-sharing amounts, including co-pays, 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 payments for which I am financially responsible is due at the time of services.**

Patient Signature: _____ **Date:** _____

Did you bring your immunization record card with you? **Yes** ○ **No** ○

It is important for you to have a personal record of your vaccinations. If you don't have a personal record we will provide you one today. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.

Section D (Immunizing Pharmacist Only) *The following section is to be completed by the immunizing pharmacist only after assessing the Screening Questions above.*
Immunizer Name (print): _____ **Immunizer Signature:** _____ **RPh/PharmD (circle one)**
Administration Date: _____ **Date VIS given to Patient:** _____
Patient Should Not Be Vaccinated at this Time ☐ **For this reason:** _____ **Explained to Patient:** ☐

Vaccine	Lot #	Exp Date	Manufacturer	Dosage	Circle Site of Injection	VIS Date	Date PNL Sent
Inactivated Influenza	UI815AA	6/30/18	SANOFI	0.5 ml	L / R Deltoid	8/7/15	
Pneumococcal polysaccharide				0.5ml	L / R Deltoid IM		
Zoster				0.65 ml	Posterolateral fat of upper arm		
Meningococcal				0.5 ml	Posterolateral fat of upper arm		