Candlewood Drugs
11 State Route 37
New Fairfield, CT 06812

Adult Form

rev. 10/21/16

Vaccine Administration Record (VAR) Informed Consent for Vaccination For all Health Care Providers

PATIENT COMPLETE SECTIONS A, B, C

SECTION A

Home Phone: _____ Date of Birth: _____ Age: _____ Gender: M____F___

First Name: _____ MI: _____ Last Name: _____

Home Address: _____ City: _____ State: ____ Zip Code: _____

Email Address: _____

Primary Care Physician ***FULL*** Name: _____ Physician Phone: _____

Physician Address: _____ City: _____ State: ___ Zip Code: _____

Medicare Part B Number (if applicable): ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Circle Requested Vaccine: Flu Shot Pneumonia Other: _____

SECTION B

Please answer questions 1 - 9	YES	NO	I don't know
1.Which vaccines are you requesting to have administered today?			
2.Do you feel sick today?			
3.Do you have allergies to medications, food or any vaccine? (Ex: eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, or timerosal). If yes, please list allergies.			
4.Have you received any vaccinations in the past 4 weeks? If yes, please list the immunization.			
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 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 OR do you smoke OR have a chronic condition (such as asthma or diabetes)?			
8. If you answered YES to question #7, have you ever had a pneumococcal, or "pneumonia," vaccination?			
9. For women: Are you pregnant or considering becoming pregnant in the next month?			

SECTION C

I certify that I am: (i) the Patient and at least 18 years of age; (ii) the parent or legal guardian of the minor as required by state law; or (iii) the legal guardian of the Patient. Further, I hereby give my consent to the health care provider of Candlewood Drugs 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 vaccines(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 acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation by the administering health care provider. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless Candlewood Drugs, 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 vaccines(s) listed above. I authorize Candlewood Drugs, as applicable, to release any medical or other information to my health care professionals, Medicare, Medicaid or other third party payer necessary to effectuate care or payment and requested that payment and request that payment of authorized benefits be made on my behalf to Candlewood Drugs, as applicable, with respect to the vaccine(s) listed above.

Signature: _____ Date: _____

For Pharmacy Use only

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SECTION D (To be completed by health care professional)

Immunizer Name: _____ Immunizer Signature: _____

Circle one: RPh/ PharmD/ RN/ LVN / NP /PA

Vaccine	Lot #	Exp.	Manufacture	Dosage	Circle Site	VIS	Date
Inactivated Influenza							
Pneumococcal							
Zostavax							
Other:							