COVID-19 Vaccine Administration Record (VAR)

SIDE A – FOR PATIENT USE

HOMETOWN PHARMACY

PATIENT INFORMATION

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

ADDRESS | **CITY** | **STATE** | **ZIP**

PHONE NUMBER | **EMAIL**

PRIMARY CARE PROVIDER NAME | **EMERGENCY CONTACT NAME** | **EMERGENCY CONTACT PHONE NUMBER**

RACE/ETHNICITY

❑Declined ❑Asian/Pacific Islander ❑Hispanic ❑Multi-racial

❑American Indian/Alaskan Native ❑Black (Not of Hispanic Origin) ❑White (Not of Hispanic Origin) ❑Other:_____

OCCUPATION/STATUS

❑Healthcare Provider ❑LTC Employee or Resident ❑Over the Age of 65 ❑Essential Worker

❑Other:_____

PAYMENT INFORMATION

❑COMMERCIAL INSURANCE/PART D

Plan Name ID#

Group# BIN# PCN#

❑MEDICARE

Medicare#

❑UNINSURED

I do not have any insurance, including but not limited to, Medicare, Medicaid, or any other private or government-funded benefit plan.

VACCINE REQUESTED

❑COVID-19: 1st Dose ❑COVID-19: 2nd Dose If applicable, what date did you receive your 1st dose on? _____

PRECAUTIONS & CONTRAINDICATIONS

1. Have you been diagnosed with COVID-19 in the previous 90 Days? ❑Yes ❑No
2. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to food, medicine, previous vaccine or other? ❑Yes ❑No

   If yes, please specify reaction and if it required use of epinephrine:

   _____

   _____
3. Have you received any vaccines in the past 14 days? ❑Yes ❑No
4. Have you received monoclonal antibodies or convalescent plasma as part of a COVID-19 treatment within the past 90 days? ❑Yes ❑No
5. Are you currently sick or have a fever? ❑Yes ❑No
6. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies? ❑Yes ❑No
7. Do you have a bleeding disorder or are on a blood thinner? ❑Yes ❑No
8. Are you pregnant or breast feeding? ❑Yes ❑No

INFORMED CONSENT

I understand the benefits and risks of the COVID-19 vaccine as described in the Emergency Use Authorization (EUA) Fact Sheet, a copy of which I was provided with this Consent Form. I have had a chance to ask questions that were answered to my satisfaction. I request the vaccine to be given to me or to the person named above, a minor for whom I represent that I am authorized to sign this Consent Form. I understand that at this time, the COVID-19 vaccine requires 2 doses given 21-28 days apart depending on the manufacturer. If this is my first dose of the COVID-19 vaccine, I intend to receive a second dose of the same vaccine in accordance with the time frame specified in the Fact Sheet to complete the vaccination series. I agree to stay in the vaccine administration area for fifteen (15) minutes or longer if indicated by the vaccine administrator after receiving my vaccine to ensure that no immediate adverse reactions occur. Hometown Pharmacy participates in the Wisconsin Immunization Registry (WIR) Program by entering patient's vaccinations into this registry. Participation in the WIR Program is required for administration of the COVID-19 vaccine. By receiving this vaccination, you agree to allow Hometown Pharmacy to input your vaccination record for COVID-19 into the WIR.

SIGNATURE **DATE**

COVID-19 Vaccine Administration Record (VAR)

SIDE B – FOR PHARMACY USE ONLY

HOMETOWN PHARMACY

VACCINE INFORMATION

❑ **COVID-19 Vaccine** manufactured by Moderna
❑ **COVID-19 Vaccine** manufactured by Pfizer
❑ **COVID-19 Vaccine** manufactured by Other: _____

❑ Dose #1
❑ Dose #2

LOT # _____

EXP. DATE _____

VACCINE ADMINISTRATION

SITE OF INJECTION

ROUTE:
❑ Intramuscular (IM)
❑ Subcutaneous (SC)

SITE:
❑ Deltoid Muscle
❑ Anterolateral Thigh

SIDE
❑ Left
❑ Right

NOTES:

_____
_____
_____
_____

OBSERVATION PERIOD

TIME:
❑ 15 Minutes
❑ 30 Minutes

NOTES:

_____
_____
_____
_____

ADDITIONAL QUESTIONS

1. Was patient given most recent EUA (Emergency Use Authorization Fact Sheet)? ❑ Yes ❑ No
2. Was the WIR (Wisconsin Immunization Registry) checked prior to immunization? ❑ Yes ❑ No
3. Did the patient bring an immunization record card with them? ❑ Yes ❑ No
4. Did you give them a new immunization record card? ❑ Yes ❑ No
5. Did the patient have an adverse reaction to the vaccine? ❑ Yes ❑ No

   If yes, please describe: _____
   _____
   _____
   _____
   _____
   _____

6. Side A of this form was completed by: ❑ Patient ❑ Caregiver: _____

FORM REVIEWED BY _____ DATE _____

VACCINE ADMINISTRATOR SIGNATURE _____ DATE _____

*** Place Rx Sticker Here ***

HOMETOWN PHARMACY

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