College of Pharmacy
NOVA SOUTHEASTERN UNIVERSITY | NSU Florida

Documented in FLSHOTS by _____ on _____

DEPARTMENT OF PHARMACY SERVICES
NSU CLINIC PHARMACY
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. Please answer the following questions:

INACTIVATED VACCINES	YES	NO	DON'T KNOW
1. Which vaccine(s) are you requesting to have administered today? Please check all requested vaccination: □ **Flu Shot** □ **Pneumonia** □ **Shingles** □ **Meningitis** □ **Other:** _____			
2. Do you feel sick today?			
3. Do you have allergies to medications, food, or vaccines? (Ex: 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?			

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)

Immunizer Name (print): _____ **Immunizer Signature:** _____ **RPh/PharmD (circle)**
Administration Date: _____ **Date VIS given to Patient:** _____
Patient Should Not Be Vaccinated at this Time □ Due to: _____ **Explained to Patient:** Y / N

Vaccine	Lot #	Exp Date	Manufacturer	Dosage	Circle Site of Injection	VIS Date	Date PNL Sent
Inactivated Influenza				0.5 ml	L / R Deltoid IM		
PPSV23				0.5ml	L / R Deltoid IM		
PCV13				0.5ml	L / R Deltoid IM		
Shingles				0.5 ml	L / R Deltoid IM		
Other:							