**NORD'S PHARMACY AND GIFTS 115 N. Johnson Ave, Fosston, MN P: 218-435-6646 F: 218-435-6493**

# Vaccine Administration Record (VAR) Informed Consent for Vaccination

**First Name**_____**MI**_____**Last Name**_____

**Date of Birth**_____Home Phone_____Age_____Gender_____

Home Address_____City_____State____Zip_____

**Primary Care Physician**_____Physician Phone_____

**The following questions will help us determine your eligibility to be vaccinated today.**

*1.Which vaccines are you requesting to have administered today?*_____

*2.Do you feel sick today (fever, diarrhea, vomiting)?*_____

*3.Do you have allegies to medication, food or vaccines? (Examples: eggs,bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol or thimerosal) If yes, please list*_____

*4.Have you received any vaccinations or skin tests in the past four weeks?*_____

*5.Have you ever had a serious reaction to an influenza vaccine or any other vaccine in the past?*_____

*6.Have you ever had seizure disorder for which you are on seizure mediation(s), a brain disorder, Guillain-Barré syndrome (a condition that causes paralysis) or other nervous system problem?*_____

*7. For women: Are you pregnant or considering becoming pregnant in the next month?*_____

*8.Do you have a bleeding disorder or take 'blood thinners' such as Coumadin or heparin?*_____

For Live Vaccines:

*9.Are you currnently on home infusions, weekly injections, steroid therapy, anticancer drugs or radiation treatments?*_____

*10.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?*_____

*11.Have you received a transfusion of blood or blood products, or been given medicine called immune (gamma) globulin in the past year?*_____

I certify that I am the patient and at least 18 years of age. Further I hereby give my consent to the healthcare provider of Nord's Pharmacy and Gifts to administer the vaccine(s) I have requested above. I understand that it is not possible to predict all possible complications or side effects associated with receiving vaccines(s). I understand the risks and benefits associated with the above vaccine(s) and have received the Vaccine Information Statement of the vaccine(s) I have elected to receive. 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. Nord's reports immunization information to the Minnesota State Registry; please notify the pharmacist if you would like to fill out an Opt Out form to stop your participation in this reporting activity to MIIC.

**Patient Signature**:_____ **Date**_____

Immunizer Name_____Immunizer Signature_____Rph

Administration Date_____Date VIS given to Patient_____

| Vaccine | Lot# | Exp Date | Mfg | Dosage | Site | VIS Date | RPH Prefill |
|---|---|---|---|---|---|---|---|
| | | | | | L/R SubQ/IM | | |

Insurance Provider: _____ ID Number: _____