STUDENT HEALTH CENTER PHARMACY

Prescriber: C.Aaron Ross; SIG: One Dose As Directed; #1 Dose; RF X _____

**Vaccine Administration Record (VAR) Informed Consent for Vaccination For All Health Care Providers***
**PATIENT: COMPLETE SECTIONS A,B,C**

**SECTION A** **(PLEASE PRINT CLEARLY)**

Cell Phone | Date of Birth | Age | Gender | Male | Female

First Name | MI | Last Name

Home Address | City | State | Zip Code

Primary Care Physician Name | Physician Phone

SECTION B The following questions will help us determine your eligibility to be vaccinated today. For All Vaccines: Please answer questions 2-10.

| | | YES | NO |
|---|---|---|---|
| 1. | Which vaccines are you requesting to have administered today? (PLEASE CIRCLE): **1) FLU 2) PNEUMONIA (13 -OR- 23) 3) GARDASIL (HPV) 4) Tdap 5) Td (TETANUS) 6) SHINGRIX (SHINGLES) 7) VARICELLA (CHICKEN POX) 8) HEPATITIS A 9) HEPATITIS B 10) MENINGITIS B 11) MENINGITIS ACYW (REQUIRED) 12) MMR-II 13) IMOVAX (RABIES) 14) Covid-19** | | |
| 2. | Do you feel sick today? | ___ | ___ |
| 3. | Do you have allergies to medications, food or any vaccine? (EX. Eggs, Bovine Protein, Gelatin, Gentamycin, Polymyxin, Neomycin, Phenol or Thimerosal) **If Yes, Please List:** | ___ | ___ |
| 4. | Have you received any vaccinations in the past 4 weeks**? If yes, Please list:** | ___ | ___ |
| 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 take seizure medication(s),a brain disorder, Guillain-Barre Syndrome, or other nervous system problem? | ___ | ___ |
| 7. | Are you 65 years of age or older OR do you smoke OR have a chronic condition like asthma or diabetes? | ___ | ___ |
| 8. | If you answered YES to question #7, have you ever had a pneumococcal, or "pneumonia" vaccination? | ___ | ___ |
| 9. | Do you currently take any blood thinning medication (ex: Warfarin, Coumadin, Xarelto, etc) | ___ | ___ |
| 10. | 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 patient; or (iii) the legal guardian of the patient. Further, I hereby give my consent to the health care provider of Keystone Pharmacy Services, D/B/A UT Student Health Center Pharmacy or an employee of the University of Tennessee to administer the vaccine 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 associated Vaccine Information Sheet and have had time to ask any questions that I may have had. I have also been instructed to remain in near the vaccination location for 15 minutes after my vaccination for observation by the administering healthcare provider. On my behalf, I hereby release Keystone Pharmacy Services D/B/A UT Student Health Center Pharmacy or the University of Tennessee, as applicable, 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.

**SIGNATURE:**_____ **DATE:**_____

**SECTION D (HEALTH CARE PROVIDERS ONLY)** *The following section is to be completed by the health care provider only.*

Immunizer Name (Print):_____
Immunizer Signature:_____RPH/PharmD/Intern/MD/RN/LPN
Did the patient receive any prophylactic medication today (ex: Acetaminophen, Ibuprofen)? If so please list: _____

| Vaccine | Lot# | Exp. Date | Manufacturer | Dosage | Injection Site | VIS Date |
|---|---|---|---|---|---|---|
| **Influenza IV 2020-2021** | | **06/04/2021** | **Seqirus** | **0.5ML** | **L / R Deltoid IM / SUBQ** | **08/15/2019** |
| | | | | **0.5 ML** | **L / R Deltoid IM / SUBQ** | **_____** |
| | | | | **0.5 ML** | **L / R Deltoid IM / SUBQ** | **_____** |