Vaccine Administration Record (VAR)
Informed Consent for Vaccination

SECTION A-1

First Name: _____ **Last Name:** _____

Date of Birth: _____ **Age:** _____ **Gender:** ❑ Male ❑ Female ❑ Prefer Not To Respond

Facility Name: _____ **Address:** _____

City/Town: _____ **State:** _____ **Zip:** _____ **Email:** _____

Race: ❑ American Indian or Alaska Native ❑ Native Hawaiian or Other Pacific Islander ❑ Black or African American
❑ Asian ❑ White ❑ Other Race ❑ Unknown ❑ Unable to report due to policy/law

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Unknown ethnicity ❑ Unable to report due to policy/law

I want to receive the following vaccination: COVID-19 Vaccination **Patient Type:** ❑ Resident ❑ Staff Member

SECTION A-2 INSURANCE – PATIENT OR AUTHORIZED PERSON TO COMPLETE

	Pharmacy Card	Medical Card
Insurance Plan/Plan ID:		
Member/Recipient ID#		
RX BIN		**N/A**
RX PCN		**N/A**
Group Number:		

Medicare	**Medicare Part B**
Medicare Number*:	
Last 4 digits of SSN:**	
**Number on Red, White, and Blue Medicare Card*	
***For Insurance Confirmation Purposes Only*	
Provide Driver's License # or State ID # (circle one):	**Issuance State**
**For Verification and Coverage*	***Initial:*** _____

Is the patient the cardholder? ❑ Yes ❑ No ❑ I Don't know
If no, please provide cardholder's name, date of birth (MM/DD/YYYY) and relationship:

_____

Healthcare Provider Only: Individual refused to provide insurance information when I attempted to obtain the insurance information from the individual ❑ Yes

If uninsured: I attest that I do not have any medical or pharmacy insurance ❑ Yes

SECTION B

I certify that I am (a) the patient and at least 18 years of age; (b) the legal guardian of the patient or (c) a person authorized to consent on behalf of the patient where the patient is not otherwise competent or unable to consent for themselves. Further, I hereby give my consent to Sudbury Pharmacy and the licensed healthcare professional administering the vaccine, as applicable (each an "applicable provider") 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 EUA Fact Sheet 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 that the patient should remain near the vaccination location for observation for approximately 15 minutes after administration. On behalf of the patient, the patient's heirs, and personal representatives, I hereby release and hold harmless each applicable Provider, 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 listed above.

I acknowledge that (a) I understand the purposes/benefits of my state's vaccination registry ("State Registry") and my state's health information exchange ("State HIE"); and (b) the applicable Provider may disclose my vaccination information to the State Registry, to the State HIE or through the State HIE to the State Registry, or to any state or federal governmental agencies or authorities ("Government Agencies"), such as state county, or local Departments of Health or the federal Department of Health and Human Services, the Center for Disease Control and Prevention, or their respective designees as may be required by law, for the purposes of public health reporting, or to my healthcare providers enrolled in the State Registry and/or State HIE for purposes of care coordination. I acknowledge that, depending upon my state's law, I may prevent by using a state-approved opt-out form or, as permitted by my state law, and opt-out form ("Opt-Out Form") furnished by the applicable Provider (a) the disclosure of my vaccination information by the applicable Provider to the State HIE and/or State Registry from sharing my vaccination information with any of my other healthcare providers enrolled in the State Registry and/or State HIE. The applicable Provider will, if my state permits, provide me with an Opt-Out Form. I understand that, depending on my state's law, I may need to specifically consent, and to the extent required by my state's law, by signing below, I hereby do consent to the applicable Provider reporting my vaccination information to the Government Agencies, State HIE, or through the State HIE and/or State Registry to the entities and for the purposes described in this Informed Consent form. Unless I provide the applicable Provider with a signed Opt-Out Form, I understand that my consent will remain in effect until I withdraw my permission and that I may withdraw my consent by providing a completed Opt-Out Form to the applicable Provider and/or my State HIE, as applicable.

I understand that even if I do not consent or if I withdraw my consent, my state's laws or federal law may permit certain disclosures of my vaccination information to or through the State HIE or to Government Agencies as required or permitted by law. I further authorize the applicable Provider to (a) release my medical or other information including any communicable disease (including HIV) and mental health information to, or through, the State HIE or Government Agencies to my healthcare professionals, Medicare, Medicaid, or other third-party payer as necessary to effectuate care or payment; (b) submit a claim to my insurer for the above requested items and services; and (c) request payment of authorized benefits be made on my behalf to the applicable Provider with respect to the above requested items and services, as well as for any requested items and services not covered by my insurance benefits. I understand that any payment for which I am financially responsible is due at the time of service, or if the applicable Provider invoices me after the time of service, upon receipt of such invoice. Sudbury Pharmacy or its affiliates my contact you, including by autodialed and prerecorded calls and texts, at any time using the contact information provided in your patient record regarding health and safety matters, such as vaccine reminders, regardless of whether you have opted out of being contacted.

Print Name: _____ **Patient/Authorized person Signature:** _____ **Date:** _____