Source address:   State:   Last name:   Debt Title:   Dob Title:   D	Vaco	cine Administration Record	I (VAR)	—Informed Co	onsent for <b>V</b>	accinal	tion	Te)	ala	reens
SECTION   Please print clearly.   Last name:   Dob Title:   Dob Title:   Date of birth:   Age:   Gender:   Female   Male   Phone:							HED ID:			
Date of births:  Date of births:  Age: Gender:  Fremale Male Phone:  Fremale Male Phone:  Twish to receive text message alerts regarding my prescriptions.  Home address:  ZIP code:  Email address:  City:  State:  ZIP code:  Email address:  Cother Race:  Other Race:  American Indian or Alaska Native Asian Native Havailan or Other Pacific Islander Black or African American White Unknown Children Race:  Phone:  Children Race:  Phone:  Address:  City:  State:  ZIP code:  Fremale Male Phone:  Children Race:  Children Race:  Phone:  Address:  Address:  City:  State:  ZIP code:  I want to receive the following vaccination information from this visit to your doctor/ primary care provider using the contact information provided below Doctor/ primary care provider using the contact information provided below Doctor/ primary care provider using the contact information provided below Doctor/ primary care provider using the contact information provided below Doctor/ primary care provider using the contact information provided below Doctor/ primary care provider using the contact information provided below Doctor/ primary care provider using the contact information provided below Doctor/ primary care provider using the contact information provided below Doctor/ primary care provider using the contact information provided below Doctor/ primary care provider using the contact information provided below Doctor/ primary care provider using the contact information provided below Doctor/ primary care provider using the contact information provided below Doctor/ primary care provider using the contact information provided below Doctor/ primary care provider using the contact information provided below Doctor/ primary care provider using the contact information provided below Doctor/ primary care provider using the contact information provided below Doctor/ primary care provid	30016	audi ess.								
Date of birth:  I wish to receive text message alerts regarding my prescriptions.  Home address:  State:  ZIP code:  Enall address:  City:  State:  ZIP code:  Black or African American Other Race:  Cher Race:	SEC	TION A Please print clearly.					Job Title:			_
Twish to receive text message alerts regarding my prescriptions.    City:   State:   ZIP code:   Email address:   City:   State:   ZIP code:   Email address:   City:   State:   ZIP code:   Unknown Rative Hawaiian or Other Pacific Islander   Black or African American   White Other Race   Unknown ethnicity   Hispanic or Latino   Not Hispanic or Latino   Unknown ethnicity   Walgreens will send vaccination information from this visit to your doctor/primary care provider using the contact information provided below Doctor/primary care provider name:   Phone:   Address:   ZIP code:   ZIP code:						ame:				
State: ZIP code:   Email address:   City:   State: ZIP code:   Email address:   Native Hawaiian or Other Pacific Islander   Black or African American   White	Date	of birth:	Age: _	Gende	<b>er:</b> Female	Male	Phone:			
State: ZIP code: Email address:  Race: American Indian or Alaska Native Asian Native Hawaiian or Other Pacific Islander Black or African American White Other Race — Unknown  Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown ethnicity  Walgreens will send vaccination information from this visit to your doctor/primary care provider using the contact information provided belox Doctor/primary care provider name: Phone:  Address: City: State: ZIP code: I want to receive the following vaccination(s):  SECTION B The following questions will help us determine your eligibility to be vaccinated today.  All vaccines  1. Do you feel sick today? Yes No Don't know Pool 1 feel sick today Yes No Don't know Pool 1 feel sick today Yes No Don't know Pool 1 feel sick today Yes No Don't know Pool 1 feel sick today Yes Pool 1 feel sick today Yes No Don't know Yes Pool 1 feel sick today Yes Pool 1 feel sick today Yes Pool 1 feel sick today Yes Pool 1 f	Ιw	ish to receive text message alert	s regardii	ng my prescriptio	ns.					
State: ZIP code: Email address:  Race: American Indian or Alaska Native Asian Native Hawaiian or Other Pacific Islander Black or African American White Other Race — Unknown  Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown ethnicity  Walgreens will send vaccination information from this visit to your doctor/primary care provider using the contact information provided belox Doctor/primary care provider name: Phone:  Address: City: State: ZIP code: I want to receive the following vaccination(s):  SECTION B The following questions will help us determine your eligibility to be vaccinated today.  All vaccines  1. Do you feel sick today? Yes No Don't know Pool 1 feel sick today Yes No Don't know Pool 1 feel sick today Yes No Don't know Pool 1 feel sick today Yes No Don't know Pool 1 feel sick today Yes Pool 1 feel sick today Yes No Don't know Yes Pool 1 feel sick today Yes Pool 1 feel sick today Yes Pool 1 feel sick today Yes Pool 1 f	Home	address:					City:			
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Walgreens will send vaccination information from this visit to your doctor/ primary care provider using the contact information provided below Doctor / primary care provider name:    Phone:	Ethni	city: Hispanic or Latino Not His	spanic or La	atino Unknown	ethnicity					
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Address: City: State: ZIP code: I want to receive the following vaccination(s):    I want to receive the following questions will help us determine your eligibility to be vaccinated today.   All vaccines										
The following questions will help us determine your eligibility to be vaccinated today.  All vaccines  1. Do you feel sick today? 1. Have you been diagnosed with or tested positive for COVID-19 in the last 14 days? 2. Do you have a history of allergic reaction or allergies to latex, medications, food or vaccines (examples: polyethylene glycol, polysorbate, eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal)?  5. Have you ever had a reaction after receiving a vaccination, including fainting or feeling dizzy? 3. Have you ever had a reaction after receiving a vaccination, including fainting or feeling dizzy? 4. Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-Barré syndrome (a condition that causes paralysis) or other nervous system problem?  5. Have you ever had a reaction after receiving a vaccination, including fainting or feeling dizzy? 5. Have you ever had a reaction after receiving a vaccination, including fainting or feeling dizzy? 6. Have you ever had a reaction after receiving a vaccination, including fainting or feeling dizzy? 7. Have you received any vaccinations or skin tests in the past eight weeks? 8. Have you ever received the following vaccinations? 9. Peneumonia: Date received 9. Do you have any chronic health conditions such as cancer, chronic kidney disease, immunocompromised, chronic lung disease, observed whosping cough: Date received 9. Do you have any chronic health conditions such as cancer, chronic kidney disease, immunocompromised, chronic lung disease, observed whosping cough: Date received whosping sease, diabetes, asthma or heart disease? 9. For Communic Date received 9. Do you have any chronic health conditions such as tenated with antibody therapy specifically for COVID-19 (monoclonal antibodies yes No Don't known or convalescent plasma)? 9. For Courtenty or home infusions, weekly injections such as Humira' (adalimumably, Bernicade' (infliximab) or Enbrel' 9. Yes No Don't known (etcane										
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All vaccines  1. Do you feel sick today? 1. Do you feel sick today? 2. Have you been diagnosed with or tested positive for COVID-19 in the last 14 days? 3. In the past 14 days have you been identified as a close contact to someone with COVID-19? 4. Do you have a history of allergic reaction or allergies to latex, medications, food or vaccines (examples: polyethylene glycol, yes No Don't knot polysorbate, eggs, bovine protein, gelating, pethamicin, polymyxin, neomycin, phenol, yeast or thimerosal)? If yes, please list: 5. Have you ever had a reaction after receiving a vaccination, including fainting or feeling dizzy? 5. Have you ever had a reaction after receiving a vaccination, including fainting or feeling dizzy? 7. Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-Barré syndrome 8. Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-Barré syndrome 9. Have you received any vaccinations or skin tests in the past eight weeks? 9. Pheumonia: Date received 9. Do you have any chronic health conditions such as cancer, chronic kidney disease, immunocompromised, chronic lung disease, 9. Pheumonia: Date received 9. Do you have any chronic health conditions such as cancer, chronic kidney disease, immunocompromised, chronic lung disease, 9. Pro women: Are you pregnant or considering becoming pregnant in the next month? 9. For Chickenpox, MMR® 11, shingles, Vaxchora®, yellow fever only: 9. Answer the following questions only if you are receiving any vaccinations listed above. 9. To you have a condition that may weaken your immune system (e.g., cancer, leukemia, lymphoma, HIV/AIDS, transplant)? 9. Yes No Don't know (etanercept), high-dose enterior therapy (predisions > 2 (panglyday or equivalent) for longer or radiation treatments? 9. Por Chickenpox, MMR® 12, shingles, Vaxchora®, yellow fever only: 9. Answer the following questions only if you are receiving any vaccinations listed above. 9. To you have a conditi	1 wai	it to receive the following vaccin	ation(s).							
All vaccines  1. Do you feel sick today? 1. Do you feel sick today? 2. Have you been diagnosed with or tested positive for COVID-19 in the last 14 days? 3. In the past 14 days have you been identified as a close contact to someone with COVID-19? 4. Do you have a history of allergic reaction or allergies to latex, medications, food or vaccines (examples: polyethylene glycol, yes No Don't knot polysorbate, eggs, bovine protein, gelating, pethamicin, polymyxin, neomycin, phenol, yeast or thimerosal)? If yes, please list: 5. Have you ever had a reaction after receiving a vaccination, including fainting or feeling dizzy? 5. Have you ever had a reaction after receiving a vaccination, including fainting or feeling dizzy? 7. Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-Barré syndrome 8. Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-Barré syndrome 9. Have you received any vaccinations or skin tests in the past eight weeks? 9. Pheumonia: Date received 9. Do you have any chronic health conditions such as cancer, chronic kidney disease, immunocompromised, chronic lung disease, 9. Pheumonia: Date received 9. Do you have any chronic health conditions such as cancer, chronic kidney disease, immunocompromised, chronic lung disease, 9. Pro women: Are you pregnant or considering becoming pregnant in the next month? 9. For Chickenpox, MMR® 11, shingles, Vaxchora®, yellow fever only: 9. Answer the following questions only if you are receiving any vaccinations listed above. 9. To you have a condition that may weaken your immune system (e.g., cancer, leukemia, lymphoma, HIV/AIDS, transplant)? 9. Yes No Don't know (etanercept), high-dose enterior therapy (predisions > 2 (panglyday or equivalent) for longer or radiation treatments? 9. Por Chickenpox, MMR® 12, shingles, Vaxchora®, yellow fever only: 9. Answer the following questions only if you are receiving any vaccinations listed above. 9. To you have a conditi	SEC	TION B The following questions w	ill help us	determine your elig	ibility to be vac	cinated to	day.			
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2. Have you been diagnosed with or tested positive for COVID-19 in the last 14 days?  3. In the past 14 days have you been identified as a close contact to someone with COVID-19?  3. Do you have a history of allergic reaction or allergies to latex, medications, food or vaccines (examples: polyethylene glycol, polysorbate, eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal)?  3. If yes, please list:  4. Have you ever had a reaction after receiving a vaccination, including fainting or feeling dizzy?  4. Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-Barré syndrome (a condition that causes paralysis) or other nervous system problem?  5. Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-Barré syndrome (a condition that causes paralysis) or other nervous system problem?  7. Have you received any vaccinations or skin tests in the past eight weeks?  8. Have you ever received the following vaccinations?  9. Poeu you have any chronic health conditions such as cancer, chronic kidney disease, immunocompromised, chronic lung disease, obesity, sickle cell disease, diabetes, asthma or heart disease?  10. For Women: Are you pregnant or considering becoming pregnant in the next month?  11. For COVID-19 vaccine only: Have you been treated with antibody therapy specifically for COVID-19 (monoclonal antibodies Yes No Don't known or convalescent plasma)?  For chickenpox, MMR® II, shingles, Vaxchora®, yellow fever only:  12. Do you have a condition that may weaken your immune system (e.g., cancer, leukemia, lymphoma, HIV/AIDS, transplant)?  13. Are you currently on home infusions, weekly injections such as Humira® (adalimumab), Remicade® (infiliximab) or Enbre® Yes No Don't known (etamercept), high-dose methotrexate, azathioprine or 6-mercaptopurine, antivirials, anticancer days or radiation treatments?  14. Are you currently taking high-dose steroid therapy (prednisone > 20								Yes	Nο	Don't know
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If yes, please list:  5. Have you ever had a reaction after receiving a vaccination, including fainting or feeling dizzy?  6. Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-Barré syndrome (a condition that causes paralysis) or other nervous system problem?  7. Have you received any vaccinations or skin tests in the past eight weeks? (by lease list:  8. Have you ever had a reaction after received may vaccinations? (conditions a present of the past eight weeks? (conditions a present of the past eight weeks? (conditions a past erceived may vaccinations or skin tests in the past eight weeks? (conditions a past erceived may vaccinations? (conditions) (c	4. D	you have a history of allergic reaction	or allergies	to latex, medications	s, food or vaccin	es (example	es: polyethylene glycol,	Yes	No	Don't know
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If yes, please list:  Have you ever received the following vaccinations?  Pneumonia: Date received  Shingles: Date received  Whooping cough: Date received  9. Do you have any chronic health conditions such as cancer, chronic kidney disease, immunocompromised, chronic lung disease, obesity, sickle cell disease, diabetes, asthma or heart disease?  If yes, please list:  10. For women: Are you pregnant or considering becoming pregnant in the next month?  11. For COVID-19 vaccine only: Have you been treated with antibody therapy specifically for COVID-19 (monoclonal antibodies Yes No Don't known or convalescent plasma)?  For chickenpox, MMR® II, shingles, Vaxchora®, yellow fever only:  Answer the following questions only if you are receiving any vaccinations listed above.  12. Do you have a condition that may weaken your immune system (e.g., cancer, leukemia, lymphoma, HIV/AIDS, transplant)?  Yes No Don't known (etanercept), high-dose methotrexate, azathioprine or 6-mercaptopurine, antivirals, anticancer drugs or radiation treatments?  14. Are you currently taking high-dose steroid therapy (prednisone > 20mg/day or equivalent) for longer than 2 weeks?  Yes No Don't known in the past year?  15. Do you have a history of thymus disease (including myasthenia gravis, DiGeorge syndrome or thymoma), or had your thymus removed? (yellow fever only)  17. Do you have a history of thrombocytopenia or thrombocytopenic purpura? (MMR only)  Yes No Don't known thymus removed? (yellow fever only)  Yes No Don't known thymus removed? (yellow fever only)					ation(s), a brain	disorder, Gu	uillain-Barré syndrome	Yes	No	Don't know
Pneumonia: Date received  Shingles: Date received  Whooping cough: Date received  Do you have any chronic health conditions such as cancer, chronic kidney disease, immunocompromised, chronic lung disease, Yes No Don't known obesity, sickle cell disease, diabetes, asthma or heart disease?  If yes, please list:  10. For women: Are you pregnant or considering becoming pregnant in the next month?  11. For COVID-19 vaccine only: Have you been treated with antibody therapy specifically for COVID-19 (monoclonal antibodies Yes No Don't known or convalescent plasma)?  For chickenpox, MMR® II, shingles, Vaxchora®, yellow fever only:  Answer the following questions only if you are receiving any vaccinations listed above.  12. Do you have a condition that may weaken your immune system (e.g., cancer, leukemia, lymphoma, HIV/AIDS, transplant)? Yes No Don't known (etanercept), high-dose methotrexate, azathioprine or 6-mercaptopurine, antivirals, anticancer drugs or radiation treatments?  14. Are you currently taking high-dose steroid therapy (prednisone > 20mg/day or equivalent) for longer than 2 weeks? Yes No Don't known in the past year?  15. Have you received a transfusion of blood or blood products or been given a medication called immune (gamma) globulin Yes No Don't known in the past year?  16. Do you have a history of thymus disease (including myasthenia gravis, DiGeorge syndrome or thymoma), or had your Yes No Don't known thymus removed? (yellow fever only)  17. Do you have a history of thrombocytopenia or thrombocytopenic purpura? (MMR only)  Yes No Don't known thymus removed? (yellow fever only)			n tests in th	ne past eight weeks?				Yes	No	Don't know
9. Do you have any chronic health conditions such as cancer, chronic kidney disease, immunocompromised, chronic lung disease, obesity, sickle cell disease, diabetes, asthma or heart disease?  10. For women: Are you pregnant or considering becoming pregnant in the next month?  11. For COVID-19 vaccine only: Have you been treated with antibody therapy specifically for COVID-19 (monoclonal antibodies or convalescent plasma)?  12. For chickenpox, MMR® II, shingles, Vaxchora®, yellow fever only:  Answer the following questions only if you are receiving any vaccinations listed above.  12. Do you have a condition that may weaken your immune system (e.g., cancer, leukemia, lymphoma, HIV/AIDS, transplant)?  13. Are you currently on home infusions, weekly injections such as Humira® (adalimumab), Remicade® (infliximab) or Enbrel®  14. Are you currently taking high-dose methotrexate, azathioprine or 6-mercaptopurine, antivirals, anticancer drugs or radiation treatments?  15. Have you received a transfusion of blood or blood products or been given a medication called immune (gamma) globulin  16. Do you have a history of thymus disease (including myasthenia gravis, DiGeorge syndrome or thymoma), or had your  17. Do you have a history of thrombocytopenia or thrombocytopenic purpura? (MMR only)  18. Have you consumed any food or drink in the last hour? (Vaxchora® only)  19. Do not know thymus disease (including myasthenia gravis, DiGeorge syndrome)  19. Do not know thymus removed? (yellow fever only)	8. H			Shingles: Date re	eceived		Whooping cough: [	ate received		
If yes, please list:  10. For women: Are you pregnant or considering becoming pregnant in the next month?  11. For COVID-19 vaccine only: Have you been treated with antibody therapy specifically for COVID-19 (monoclonal antibodies Yes No Don't known or convalescent plasma)?  For chickenpox, MMR® II, shingles, Vaxchora®, yellow fever only:  Answer the following questions only if you are receiving any vaccinations listed above.  12. Do you have a condition that may weaken your immune system (e.g., cancer, leukemia, lymphoma, HIV/AIDS, transplant)? Yes No Don't known (etanercept), high-dose methotrexate, azathioprine or 6-mercaptopurine, antivirals, anticancer drugs or radiation treatments?  14. Are you currently taking high-dose steroid therapy (prednisone > 20mg/day or equivalent) for longer than 2 weeks? Yes No Don't known in the past year?  15. Have you received a transfusion of blood or blood products or been given a medication called immune (gamma) globulin Yes No Don't known in the past year?  16. Do you have a history of thymus disease (including myasthenia gravis, DiGeorge syndrome or thymoma), or had your Yes No Don't known thymus removed? (yellow fever only)  17. Do you have a history of thrombocytopenia or thrombocytopenic purpura? (MMR only)  Yes No Don't known thymus removed and prod or drink in the last hour? (Vaxchora® only)	9. D	you have any chronic health condition	s such as ca	ancer, chronic kidney					No	Don't know
11. For COVID-19 vaccine only: Have you been treated with antibody therapy specifically for COVID-19 (monoclonal antibodies or convalescent plasma)?  For chickenpox, MMR® II, shingles, Vaxchora®, yellow fever only: Answer the following questions only if you are receiving any vaccinations listed above.  12. Do you have a condition that may weaken your immune system (e.g., cancer, leukemia, lymphoma, HIV/AIDS, transplant)? Yes No Don't know (etanercept), high-dose methotrexate, azathioprine or 6-mercaptopurine, antivirals, anticancer drugs or radiation treatments?  14. Are you currently taking high-dose steroid therapy (prednisone > 20mg/day or equivalent) for longer than 2 weeks? Yes No Don't know in the past year?  15. Have you received a transfusion of blood or blood products or been given a medication called immune (gamma) globulin Yes No Don't know in the past year?  16. Do you have a history of thymus disease (including myasthenia gravis, DiGeorge syndrome or thymoma), or had your Yes No Don't know thymus removed? (yellow fever only)  17. Do you have a history of thrombocytopenia or thrombocytopenic purpura? (MMR only)  Yes No Don't know thymus disease and the last hour? (Vaxchora® only)  Yes No Don't know Do	ol	pesity, sickle cell disease, diabetes, asth	ma or heart	disease?	·	·		_		
11. For COVID-19 vaccine only: Have you been treated with antibody therapy specifically for COVID-19 (monoclonal antibodies or convalescent plasma)?  For chickenpox, MMR® II, shingles, Vaxchora®, yellow fever only: Answer the following questions only if you are receiving any vaccinations listed above.  12. Do you have a condition that may weaken your immune system (e.g., cancer, leukemia, lymphoma, HIV/AIDS, transplant)? Yes No Don't know (etanercept), high-dose methotrexate, azathioprine or 6-mercaptopurine, antivirals, anticancer drugs or radiation treatments?  14. Are you currently taking high-dose steroid therapy (prednisone > 20mg/day or equivalent) for longer than 2 weeks? Yes No Don't know in the past year?  15. Have you received a transfusion of blood or blood products or been given a medication called immune (gamma) globulin Yes No Don't know in the past year?  16. Do you have a history of thymus disease (including myasthenia gravis, DiGeorge syndrome or thymoma), or had your Yes No Don't know thymus removed? (yellow fever only)  17. Do you have a history of thrombocytopenia or thrombocytopenic purpura? (MMR only)  Yes No Don't know thymus disease and the last hour? (Vaxchora® only)  Yes No Don't know Do	10. Fo	or women: Are you pregnant or consider	ring becomi	ng pregnant in the n	ext month?			Yes	No	Don't know
Answer the following questions only if you are receiving any vaccinations listed above.  12. Do you have a condition that may weaken your immune system (e.g., cancer, leukemia, lymphoma, HIV/AIDS, transplant)?  13. Are you currently on home infusions, weekly injections such as Humira® (adalimumab), Remicade® (infliximab) or Enbrel® (etanercept), high-dose methotrexate, azathioprine or 6-mercaptopurine, antivirals, anticancer drugs or radiation treatments?  14. Are you currently taking high-dose steroid therapy (prednisone > 20mg/day or equivalent) for longer than 2 weeks?  15. Have you received a transfusion of blood or blood products or been given a medication called immune (gamma) globulin (in the past year?  16. Do you have a history of thymus disease (including myasthenia gravis, DiGeorge syndrome or thymoma), or had your thymus removed? (yellow fever only)  17. Do you have a history of thrombocytopenia or thrombocytopenic purpura? (MMR only)  18. Have you consumed any food or drink in the last hour? (Vaxchora® only)  19. Ves No Don't known on the past year.			been treat	ed with antibody ther	rapy specifically t	for COVID-	19 (monoclonal antibodies	Yes	No	Don't know
13. Are you currently on home infusions, weekly injections such as Humira® (adalimumab), Remicade® (infliximab) or Enbrel® Yes No Don't know (etanercept), high-dose methotrexate, azathioprine or 6-mercaptopurine, antivirals, anticancer drugs or radiation treatments?  14. Are you currently taking high-dose steroid therapy (prednisone > 20mg/day or equivalent) for longer than 2 weeks? Yes No Don't know in the past year?  15. Have you received a transfusion of blood or blood products or been given a medication called immune (gamma) globulin in the past year?  16. Do you have a history of thymus disease (including myasthenia gravis, DiGeorge syndrome or thymoma), or had your Yes No Don't know thymus removed? (yellow fever only)  17. Do you have a history of thrombocytopenia or thrombocytopenic purpura? (MMR only)  18. Have you consumed any food or drink in the last hour? (Vaxchora® only)  Yes No Don't know Don't kn						l above.				-
(etanercept), high-dose methotrexate, azathioprine or 6-mercaptopurine, antivirals, anticancer drugs or radiation treatments?  14. Are you currently taking high-dose steroid therapy (prednisone > 20mg/day or equivalent) for longer than 2 weeks?  15. Have you received a transfusion of blood or blood products or been given a medication called immune (gamma) globulin  16. Do you have a history of thymus disease (including myasthenia gravis, DiGeorge syndrome or thymoma), or had your  17. Do you have a history of thrombocytopenia or thrombocytopenic purpura? (MMR only)  18. Have you consumed any food or drink in the last hour? (Vaxchora® only)  Yes No Don't known only the product of the prod	12. D	you have a condition that may weaker	n your immi	une system (e.g., car	ncer, leukemia, ly	mphoma, I	HIV/AIDS, transplant)?	Yes	No	Don't know
<ul> <li>15. Have you received a transfusion of blood or blood products or been given a medication called immune (gamma) globulin Yes No Don't known in the past year?</li> <li>16. Do you have a history of thymus disease (including myasthenia gravis, DiGeorge syndrome or thymoma), or had your thymus removed? (yellow fever only)</li> <li>17. Do you have a history of thrombocytopenia or thrombocytopenic purpura? (MMR only)</li> <li>18. Have you consumed any food or drink in the last hour? (Vaxchora® only)</li> </ul>								Yes	No	Don't know
in the past year?  16. Do you have a history of thymus disease (including myasthenia gravis, DiGeorge syndrome or thymoma), or had your thymus removed? (yellow fever only)  17. Do you have a history of thrombocytopenia or thrombocytopenic purpura? (MMR only)  18. Have you consumed any food or drink in the last hour? (Vaxchora® only)  Yes No Don't known only)	14. A	re you currently taking high-dose steroid therapy (prednisone > 20mg/day or equivalent) for longer than 2 weeks?					Yes	No	Don't know	
thymus removed? (yellow fever only)  17. Do you have a history of thrombocytopenia or thrombocytopenic purpura? (MMR only)  18. Have you consumed any food or drink in the last hour? (Vaxchora® only)  Yes No Don't known only Yes No Don't known onl		•	or blood pr	oducts or been given	a medication ca	lled immun	ie (gamma) globulin	Yes	No	Don't know
18. Have you consumed any food or drink in the last hour? (Vaxchora® only)  Yes No Don't known			(including r	nyasthenia gravis, Di	George syndrom	e or thymo	ma), or had your	Yes	No	Don't know
18. Have you consumed any food or drink in the last hour? (Vaxchora® only)  Yes No Don't known	17. D	you have a history of thrombocytopen	ia or throm	bocytopenic purpura	? (MMR only)			Yes	No	Don't know
								Yes	No	Don't know
					10 days? (Vaxcho	ora® only)		Yes	No	Don't know

## SECTION C

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 Walgreens or Duane Reade 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 that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I alway the effects and the effects or complications associated with receiving vaccine(s). I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I alway the effects of the patient's provider, it is a considerable provider, it is 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'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(s) listed above. I acknowledge that: (a) I understand the purposes/benefits of my state's law, in may state's law, in my state's law, the IET'); and (b) the applicable Provider my disclose my vaccination information in information of the vaccine(s) listed above. I acknowledge that: (a) I understand that portions of the vaccine(s) listed above. I acknowledge that: (a) I understand that provider the federal Department of Health and Human Services, the Centers for Disease Control

<b>Patient signature:</b>		Date:
	(Parent or guardian, if minor)	

Initial here:  Initia	Name:							DOB: _		
Medicare mulbor:  Medicare number:  Last 4 digits of SNP:  The Med	SECTION D		INSU	JRANCE-PATI	ENT OR AUTH	ORIZED	P			
Medicare number?  Member/Ricciore ID 0 1 NA  Member/Ricciore ID 0 NA  Member/Ricc	Please ensure to	record BOTH pha	armacy AND me	dical insurance i	nformation since	there are	multiple way	s vaccinations	s can be billed a	t Walgreens.
Medicare number:  Methodispose Discharge (Park Park Discharge Composed		Pharmacy card	Medical card	Med	licare	Medicare	Part B			
Machine   Mach				Med	icare number:*					
The BRITE NAME OF THE PROPERTY	·	_			3					
The Note of the Composition of t				*Nur	nber on the red, white a insurance confirmation	and blue Medi purposes only	care card			
Tuninsured:   attest that 10 beach have any medical or pharmacy insurance.   Yes										
The you the cardholder? Yes No for please provide cardholder? Yes No for please provide cardholder state. The please provide cardholder state. The please provide cardholder state. Please of birth (MMDD TY) and relationship:  Healthcare provider only: Individual refused to provide insurance information when I attempted to obtain the insurance information from the individual. Yes SECTION E  HEALTHCARE PROVIDER ONLY  Complete BEFORE vaccine administration  Initial here:  Initial here:			N/A		_	_				
The Count of Country (MINDEPTTY) and relationship:    Healthcare provided cardholgiae trains, late of birth (MINDEPTTY) and relationship:   Healthcare provided entry Individual refused to provide insultants a lorg matter on the individual.   Yes	Group Number:							cal or pharmacy	insurance. Ye	S
Healthcare provider only: Individual refused to provide insurance information when latter of birth (IMDOPTY) and relationship:  Healthcare provider only: Individual refused to provide insurance information when latter of birth (IMDOPTY) and relationship:  HEALTHCARE PROVIDER ONLY  HEALTHCARE PROVIDER ONLY  HEALTHCARE PROVIDER ONLY  HEALTHCARE PROVIDER ONLY  Initial here:  Initial here:  Initial here:  Initial here:  3a. Does this patient have a high-risk medical condition?  If yes, please list medical condition(s):  Initial here:  The vaccine NDC matches the NDC on the bottom of this VAR form and the NDC on the patient leaflet.  (Perform 3-way NDC match.)  Initial here:  I	Are you the cardhol	lder? Yes	No		•	,	rcle one)			
Attempted to obtain the insurance information from the individual.   Yes						,	dividual refus	ed to provide		
Complete BFORE vaccine administration  1. I have reviewed the Patient Information and Screening Questions.  2. I have verified that this is the vaccine requested by the patient.  3. This vaccine is appropriate for this patient based on the Age Guidelines provided by federal and/or state regulations 3. This vaccine is particularly state for this patient based on the Age Guidelines provided by federal and/or state regulations 3. This vaccine is particularly state for this patient based on the Age Guidelines provided by federal and/or state regulations 3. This vaccine is proportiate for this patient based on the Age Guidelines provided by federal and/or state regulations 3. This vaccine NDE match is patient the patient additional immunizations the patient may be eligible for based on age and/or health conditions.  3. Initial here:  5. The Vaccine NDC matches the NDC on the bottom of this VAR form and the NDC on the patient leaflet.  5. The Vaccine NDC match, but the patient begins to the patient leaflet.  6. I have made every attempt to obtain and confirm patient insurance information.  7. I have made every attempt to obtain and confirm patient insurance information.  8. Initial here:  8. This vaccine is reconstituted following the package insert's instructions.  8. SECTION F.  Complete DURING the patient interaction  1. I have asked the patient to confirm their Name, DOB and Requested Vaccine and verified it matches the information  1. Initial here:  1. Initial here:  2. I have reviewed the VIS/Patient Fact Sheet with the patient.  3. I have reviewed the VIS/Patient Fact Sheet with the patient.  5. Initial here:  6. This vaccine is patient to determine the VIS/Patient fact Sheet with the patient.  8. Initial here:  8. Initial here:  8. Initial here:  8. Initial here:  9. Initial here:  9. Initial here:  1. Initial here:  1. I have reviewed the VIS/Patient Fact Sheet with the patient.  1. Initial here:  1. I	date of birth (MM/D	D/YYY) and relat	tionship:							_
Complete BFORE vaccine administration  1. I have reviewed the Patient Information and Screening Questions.  2. I have verified that this is the vaccine requested by the patient.  3. This vaccine is appropriate for this patient based on the Age Guidelines provided by federal and/or state regulations 3. This vaccine is particularly state for this patient based on the Age Guidelines provided by federal and/or state regulations 3. This vaccine is particularly state for this patient based on the Age Guidelines provided by federal and/or state regulations 3. This vaccine is proportiate for this patient based on the Age Guidelines provided by federal and/or state regulations 3. This vaccine NDE match is patient the patient additional immunizations the patient may be eligible for based on age and/or health conditions.  3. Initial here:  5. The Vaccine NDC matches the NDC on the bottom of this VAR form and the NDC on the patient leaflet.  5. The Vaccine NDC match, but the patient begins to the patient leaflet.  6. I have made every attempt to obtain and confirm patient insurance information.  7. I have made every attempt to obtain and confirm patient insurance information.  8. Initial here:  8. This vaccine is reconstituted following the package insert's instructions.  8. SECTION F.  Complete DURING the patient interaction  1. I have asked the patient to confirm their Name, DOB and Requested Vaccine and verified it matches the information  1. Initial here:  1. Initial here:  2. I have reviewed the VIS/Patient Fact Sheet with the patient.  3. I have reviewed the VIS/Patient Fact Sheet with the patient.  5. Initial here:  6. This vaccine is patient to determine the VIS/Patient fact Sheet with the patient.  8. Initial here:  8. Initial here:  8. Initial here:  8. Initial here:  9. Initial here:  9. Initial here:  1. Initial here:  1. I have reviewed the VIS/Patient Fact Sheet with the patient.  1. Initial here:  1. I										
Initial here:  I have verified that this is the vaccine requested by the patient.  Initial here:  Initial here:	SECTION E			Н	EALTHCARE P	ROVIDE	R ONLY			
2. I have verified that this is the vaccine requested by the patient.  3. This vaccine is appropriate for this patient based on the Age Guidelines provided by federal and/or state regulations 3. Does this patient have a high-risk medical condition? 1 f yes, please list medical condition(s):  4. I have discussed with the patient additional immunizations the patient may be eligible for based on age and/or health conditions.  5. The Vaccine NDC matches the NDC on the bottom of this VAR form and the NDC on the patient leaflet.  6. I have verified the Expiration Date is greater than today's date and have entered the Lot # and Expiration Date in the field below.  7. I have made every attempt to obtain and confirm patient insurance information.  8. Initial here:  8. For COVID-19, Shingrix's, MMR® II, Varivax's, YF-Vax's, Menveo's, Imovax's, Vaxchora's and RabAvert's, ensure the vaccine is reconstituted following the package insert's instructions.  8. SECTION F  Complete DURING the patient interaction  1. I have asked the patient to confirm their Name, DOB and Requested Vaccine and verified it matches the information in the VAR form.  2. I have reviewed the VIS/Patient Fact Sheet with the patient.  3. I have reviewed the VIS/Patient Fact Sheet with the patient.  5. I have reviewed the VIS/Patient Fact Sheet with the patient.  8. I have reviewed the VIS/Patient Fact Sheet with the patient.  8. I have reviewed the VIS/Patient Fact Sheet with the patient.  8. I have reviewed the VIS/Patient Fact Sheet with the patient.  8. I have reviewed the VIS/Patient Fact Sheet with the patient.  9. I have reviewed the VIS/Patient Fact Sheet with the patient.  9. I have reviewed the VIS/Patient Fact Sheet with the patient in the fact Sheet Published Date  1. Administration date:  1. Intitial here:  1. Intitial	Complete BEFOR	E vaccine admi	nistration							
3. This vaccine is appropriate for this patient based on the Age Guidelines provided by federal and/or state regulations and company policies.  3a. Does this patient have a high-risk medical condition?  If yes, please list medical condition(s):  4. I have discussed with the patient additional immunizations the patient may be eligible for based on age and/or health conditions.  Initial here:  5. The Vaccine NDC matches the NDC on the bottom of this VAR form and the NDC on the patient leaflet.  (Perform 3-way NDC match.)  5. I have verified the Expiration Date is greater than today's date and have entered the Lot # and Expiration Date in the field below.  Initial here:  7. I have made every attempt to obtain and confirm patient insurance information.  Initial here:  For COVID-19, Shingrix®, MMR® II, Varivax®, YF-Vax®, Menveo®, Imovax®, Vaxchora® and RabAvert®, ensure the vaccine is reconstituted following the package insert's instructions.  SECTION F  Complete DURING the patient interaction  I have reviewed the patient to confirm their Name, DOB and Requested Vaccine and verified it matches the information initial here:  I have reviewed the VIS/Patient Fact Sheet with the patient.  Initial here:  Initial here:  SECTION G  Complete AFTER vaccine administration  Vaccine  NDC  Manufacturer  Dosage  Osage  (if applicable)  Administration  Vaccine  NDC  Manufacturer  Dosage  Osage  (if applicable)  Administration  Vaccine  Clinician's name (print):  Clinician's name (print):  Administration date:  Jack EUA Fact Sheet (VIS) given to patient:  Title:  If applicable, intern/tech name (print):	1. I have reviewed	the <b>Patient In</b>	formation and	Screening Ques	stions.				Initia	I here:
3. This vaccine is appropriate for this patient based on the Age Guidelines provided by federal and/or state regulations and company policies.  3a. Does this patient have a high-risk medical condition?  If yes, please list medical condition(s):  4. I have discussed with the patient additional immunizations the patient may be eligible for based on age and/or health conditions.  Initial here:  5. The Vaccine NDC matches the NDC on the bottom of this VAR form and the NDC on the patient leaflet.  (Perform 3-way NDC match.)  5. I have verified the Expiration Date is greater than today's date and have entered the Lot # and Expiration Date in the field below.  Initial here:  7. I have made every attempt to obtain and confirm patient insurance information.  Initial here:  For COVID-19, Shingrix®, MMR® II, Varivax®, YF-Vax®, Menveo®, Imovax®, Vaxchora® and RabAvert®, ensure the vaccine is reconstituted following the package insert's instructions.  SECTION F  Complete DURING the patient interaction  I have reviewed the patient to confirm their Name, DOB and Requested Vaccine and verified it matches the information initial here:  I have reviewed the VIS/Patient Fact Sheet with the patient.  Initial here:  Initial here:  SECTION G  Complete AFTER vaccine administration  Vaccine  NDC  Manufacturer  Dosage  Osage  (if applicable)  Administration  Vaccine  NDC  Manufacturer  Dosage  Osage  (if applicable)  Administration  Vaccine  Clinician's name (print):  Clinician's name (print):  Administration date:  Jack EUA Fact Sheet (VIS) given to patient:  Title:  If applicable, intern/tech name (print):									Initia	I here:
and company policies.  3a. Does this patient have a high-risk medical condition? If yes, please list medical condition(s):  4. I have discussed with the patient additional immunizations the patient may be eligible for based on age and/or health conditions. Initial here: [Perform 3-way NDC matchs]  5. The Vaccine NDC matches the NDC on the bottom of this VAR form and the NDC on the patient leaflet. Initial here: [Perform 3-way NDC match.]  6. The vaccine NDC matches the NDC on the bottom of this VAR form and the NDC on the patient leaflet. Initial here: [Perform 3-way NDC match.]  6. I have verified the Expiration Date is greater than today's date and have entered the Lot # and Expiration Date in the field below. Initial here: [Perform 3-way NDC match.]  7. I have made every attempt to obtain and confirm patient insurance information. Initial here: [Perform 4-way NDC match.]  For COVID-19, Shingrix®, MMR® II, Varivax®, YF-Vax®, Menveo®, Imovax®, Vaxchora® and RabAvert®, ensure the vaccine is reconstituted following the package insert's instructions.  SECTION F  Complete DURING the patient interaction  1. I have asked the patient to confirm their Name, DOB and Requested Vaccine and verified it matches the information Initial here: [Initial here: [I	3. This vaccine is	appropriate for th	nis patient based	on the <b>Age Gui</b>	delines provided	by federal	and/or state i	regulations		
If yes, please list medical conditions(s): 4. I have discussed with the patient additions the patient may be eligible for based on age and/or health conditions. Initial here: 5. The Vaccine NDC matches the NDC on the bottom of this VAR form and the NDC on the patient leaflet. (Perform 3-way NDC match.) 6. I have verified the Expiration Date is greater than today's date and have entered the Lot # and Expiration Date in the field below. Initial here: 7. I have made every attempt to obtain and confirm patient insurance information. Initial here: 8. Initial here: 9. The Vaccine NMR® II, Varivax®, YF-Vax®, Menveo®, Imovax®, Vaxchora® and RabAvert®, ensure the vaccine is reconstituted following the package insert's instructions.  SECTION F  Complete DURING the patient interaction 1. I have asked the patient to confirm their Name, DOB and Requested Vaccine and verified it matches the information on the VAR form. 9. I have reviewed the Screening Questions with the patient. 9. I have reviewed the VIS/Patient Fact Sheet with the patient. 9. I have reviewed the VIS/Patient Fact Sheet with the patient.  SECTION G  Complete AFTER vaccine administration  Vaccine NDC Manufacturer Dosage Dose # (if applicable) Administration Vaccine Expiration Expiration Expiration Expiration (if applicable) Published Date  Clinician's name (print): 9. Clinician signature: 9. Title: 9. Clinician's name (print): 9. Administration date: 9. Date EUA Fact Sheet/VIS given to patient: 9. Date EUA Fact Sheet/VIS given to patient: 9. Date EUA Fact Sheet/VIS given to patient: 9. Administration date: 9. Date EUA Fact Sheet/VIS given to patient: 9. Date EUA						,	,			
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Update the patient's record with any new allergy, health condition or primary care provider information.
 Enter vaccine lot #, expiration date and site of administration, then scan the VAR form into the patient's record.



## AUTHORIZATION – FOR RELEASE OF HEALTH INFORMATION TO THIRD PARTY FLU VACCINATION FORM

By choosing to use this vaccination clinic to obtain your flu shot, your signature below allows for your flu shot information to be shared with Johns Hopkins Vaccine Management System to ensure you are in compliance with the Designated Entity's influenza vaccine policy.

Section 1: Patient information
Patient Name: Date of Birth: Street Address: City, State, Zip:
Telephone Number: ( ) E-mail Address:
Section 2: Entity authorized to receive information from Walgreens. The Johns Hopkins University and or Johns Hopkins Health System Corporation and their affiliates ("Designated Entity").
Section 3: Information you are agreeing to release: Information related to my influenza vaccination including my vaccination appointment information.
Section 4: Purpose: I am currently associated with the Designated Entity and request that the Designated Entity receive information related to influenza vaccination.
Section 5: Expiration Date: This authorization expires one year from the date of my signature.
Section 6: Information regarding this Authorization
<ul> <li>You have the right to revoke this Authorization, in writing to Walgreens Privacy Office, at any time. The revocation is only effective after it is received and logged by Walgreens. Any use or disclosure made prior to a revocation is not included as part of the revocation.</li> <li>Refer to our Notice of Privacy Practices for permitted uses and disclosures of protected health information ("PHI"). You may obtain a copy of this Notice from the Privacy Office or on <a href="www.walgreens.com">www.walgreens.com</a>. Please keep a copy of this authorization for your records.</li> <li>Once PHI is disclosed to others, it may be redisclosed by them to persons or entities that are not subject to the privacy regulations, which means that the PHI may no longer be protected by regulations.</li> <li>Privacy regulations prohibit the conditioning of treatment, payment, enrollment, or eligibility for benefits on signing this Authorization.</li> <li>This Authorization must be signed and dated by the patient or signed and dated by the patient's personal representative to include a description of that person's ability to act on behalf of the patient.</li> </ul>
Section 7: Signature
I,, by signing below, authorize Walgreens to use or disclose of my protected health information as described above.
Signature Section 8: If this Authorization is signed by the patient's personal representative, please explain your authority to act
If you have any questions regarding this form, you can contact Walgreens Privacy Office, 200 Wilmot Road, MS 2000, Deerfield, Illinois 60015: Phone: (847) 236 6518:

Fax: (847) 236-0862.