

SECTION D INSURANCE PATIENT OR AUTHORIZED PERSON TO COMPLETE

Please ensure to record BOTH pharmacy AND medical insurance information since there are multiple ways vaccinations can be billed at Project Vision Hawai'i

	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 the red, white and blue Medicare card.
†For insurance confirmation purposes only.

COVID-19 VACCINATION ONLY

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

Driver's license/State ID number* (circle one) _____ Issuing state: _____
*For verification and coverage Initial here: _____

Healthcare provider only: Individual refused to provide insurance information when I attempted to obtain the insurance information from the individual. Yes

Are you the cardholder? Yes No
If no, please provide cardholder's name, date of birth (MM/DD/YYYY) and relationship:

SECTION E HEALTHCARE PROVIDER ONLY

Complete BEFORE vaccine administration

- I have reviewed the Patient Information and Screening Questions. Initial here: _____
- I have verified that this is the vaccine requested by the patient. Initial here: _____
- This vaccine is appropriate for this patient based on the Age Guidelines provided by federal and/or state regulations and company policies. Initial here: _____
3a. Does this patient have a high-risk medical condition? Yes No
If yes, please list medical condition(s): _____
- I have discussed with the patient additional immunizations the patient may be eligible for based on age and/or health conditions. 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 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: _____
- 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 asked the patient to confirm their Name, DOB and Requested Vaccine and verified it matches the information on the VAR form. Initial here: _____
- I have reviewed the Screening Questions with the patient. Initial here: _____
- I have reviewed the VIS/Patient Fact Sheet with the patient. Initial here: _____

SECTION G

Complete AFTER vaccine administration

Vaccine	NDC	Manufacturer	Dosage	Dose # (if applicable)	Site of Administration	Vaccine Lot #	Vaccine Expiration	Diluent Lot # (if applicable)	Diluent Expiration (if applicable)	VIS/Patient Fact Sheet Published Date

Clinician's name (print): _____ Clinician signature: _____ Title: _____

If applicable, intern/tech name (print): _____ Administration date: _____

Date EUA Fact Sheet/VIS given to patient: _____

Notes

Reminder

- 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.

Vaccine Administration Record (VAR)—Informed Consent for Vaccination

Location: _____ Date: _____	Where did you sleep last night? (Circle one) Friend's home or couch surfing, Outside, My Apartment or House, Park / encampment, Shelter, Street, Vehicle	Homeless status? Y N Staff or Client Observation: _____
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SECTION A Please print clearly.

First name: _____ **Last name:** _____
Date of birth: _____ **Age:** _____ **Gender:** F M X **Phone:** _____
Home address: _____ **City:** _____
State: _____ **ZIP code:** _____ **Email address:** _____

RACE/ETHNICITY (Circle all the apply)

Native Hawaiian, Micronesian, Marshallese, Chamorro, Samoan, Tongan, Other Pacific Islander, Filipino, Chinese, Japanese, Vietnamese, Korean, Other Asian, Black/African American, Native American, Hispanic/Latino, White, Other: _____

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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
2. Have you been diagnosed with or tested positive for COVID-19 in the last 14 days?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
3. In the past 14 days have you been identified as a close contact to someone with COVID-19?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
4. 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)? If yes, please list: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
5. Have you ever had a reaction after receiving a vaccination, including fainting or feeling dizzy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
7. Have you received any vaccinations or skin tests in the past eight weeks? If yes, please list: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
8. Have you ever received the following vaccinations? <input type="checkbox"/> Pneumonia: Date received _____ <input type="checkbox"/> Shingles: Date received _____ <input type="checkbox"/> 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: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
10. For women: Are you pregnant or considering becoming pregnant in the next month?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> 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)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know

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)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
14. Are you currently taking high-dose steroid therapy (prednisone > 20mg/day or equivalent) for longer than 2 weeks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
15. Have you received a transfusion of blood or blood products or been given a medication called Immune (gamma) globulin in the past year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
16. Do you have a history of thymus disease (including myasthenia gravis, DiGeorge syndrome or thymoma), or had your thymus removed? (yellow fever only)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
17. Do you have a history of thrombocytopenia or thrombocytopenic purpura? (MMR only)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
18. Have you consumed any food or drink in the last hour? (Vaxchora® only)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
19. Have you taken antibiotics in the last 14 days or antimalarials in the last 10 days? (Vaxchora® only)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> 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 Project Vision Hawai'i 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, their 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 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 Centers for Disease Control and Prevention, or their respective designees as may be required by law, for 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, an 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; or (b) 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. I further agree to be fully financially responsible for any cost-sharing amounts, including copays, 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 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. Project Vision Hawai'i may contact you, including by autodialed and prerecorded calls and texts, and emails, using the contact information provided in your patient record regarding health and safety matters, such as vaccine reminders. I understand the benefits and risks of this vaccine and ask that the vaccine be given to me, or the person for whom I am authorized to make this request. Project Vision Hawai'i, its Board of Directors, contractors (including the State of Hawaii, its departments, agencies and employees) and staff are immune from civil liability under federal and state law for all claims for loss related to any known or unknown side effects and/or injuries, including but not limited to death, that I, or the person for whom I am authorized to make this request, may experience from this vaccine. This immunity means that if I file a lawsuit against the Project Vision Hawai'i or the State, the court must dismiss any such lawsuit, and the only exception to this immunity is for claims of willful misconduct.

Signature- Patient or Legal Guardian Date Legal Guardian Name Relation