VACCINE ADMINISTRATION RECORD (VAR) - Informed Consent for Vaccination

inspire MEDICAL GROUP OF CALIFORNIA

Inspire Medical Group of California, PC: 333 West El Camino, Suite 230, Sunnyvale, CA 94087

SECTION 1: Patient Information (Please Print)

LAST NAME	**FIRST NAME**	**MIDDLE INITIAL**
DATE OF BIRTH: MONTH DAY YEAR	**MOBILE PHONE NUMBER (PATIENT OR GUARDIAN)**	

MARITAL STATUS: ☐ Single ☐ Partnered ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

ADDRESS		**APT/ROOM #:**
CITY	**STATE**	**ZIP**
EMAIL ADDRESS		
LEGAL GUARDIAN: LAST NAME:	**FIRST NAME**	**MIDDLE INITIAL**
LEGAL SEX: ☐ Female ☐ Male ☐ Nonbinary	**ETHNICITY:** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown	

RACE: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other ☐ Pacific Islander ☐ White ☐ Other Asian ☐ Other Non-White ☐ Other Pacific Islander ☐ Unknown

PRIMARY DOCTOR'S NAME:		**PHONE NUMBER**
ADDRESS		**APT/ROOM #:**
CITY	**STATE**	**ZIP**

I WANT TO RECEIVE THE FOLLOWING VACCINATION(S):

SECTION 2: The following questions will help us determine your eligibility to be vaccinated today.

All Vaccines	
1. Are you feeling sick today?	☐ YES ☐ NO ☐ DON'T KNOW
2. Have you been diagnosed or tested positive for COVID-19 in the last 14 days?	☐ YES ☐ NO ☐ DON'T KNOW
3. In the past 14 days have you been identified as a close contact to someone with COVID-19?	☐ YES ☐ NO ☐ 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:	☐ YES ☐ NO ☐ DON'T KNOW
5. Have you ever had a reaction after receiving a vaccination, including fainting or feeling dizzy?	☐ YES ☐ NO ☐ DON'T KNOW
6. Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillan-Barré syndrome (a condition that causes paralysis), or other nervous system problem?	☐ YES ☐ NO ☐ DON'T KNOW
7. Have you received any vaccinations or skin tests in the past eight weeks? If yes, please list:	☐ YES ☐ NO ☐ DON'T KNOW
8. Have you ever received the following vaccinations? ☐ Pneumonia: Date received: ☐ Shingles: Date received: ☐ Whooping cough: Date received:	
9. Do you have any health condition such as cancer, chronic kidney disease, immunocompromised, chronic lung disease, obesity, sickle cell disease, diabetes, heart disease? If yes, please list:	☐ YES ☐ NO ☐ DON'T KNOW
10. For women: Are you pregnant or considering becoming pregnant in the next month?	☐ YES ☐ NO ☐ DON'T KNOW
For chickenpox, MMR® II, shingles, Vaxchora®, yellow fever only: Answer the following questions only if you are receiving any of these vaccinations.	
11. Do you have a condition that may weaken your immune system (e.g., cancer, leukemia, lymphoma, HIV/AIDS, transplant)?	☐ YES ☐ NO ☐ DON'T KNOW
12. 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?	☐ YES ☐ NO ☐ DON'T KNOW
13. Are you currently taking high-dose steroid therapy (prednisone > 20mg/day or equivalent) for longer than 2 weeks?	☐ YES ☐ NO ☐ DON'T KNOW
14. Have you received a transfusion of blood or blood products or been given a medication called immune (gamma) globulin in the past year?	☐ YES ☐ NO ☐ DON'T KNOW
15. Do you have a history of thymus disease (including myasthenia gravis, DiGeorge syndrome or thymoma) or had your thymus removed? (yellow fever only)	☐ YES ☐ NO ☐ DON'T KNOW
16. Do you have a history of thrombocytopenic purpura? (MMR only)	☐ YES ☐ NO ☐ DON'T KNOW
17. Have you consumed any food or drink in the past hour? (Vaxchora® only)	☐ YES ☐ NO ☐ DON'T KNOW
18. Have you taken antibiotics in the last 14 days or antimalarials in the last 10 days? (Vaxchora® only)	☐ YES ☐ NO ☐ DON'T KNOW

SECTION 3: PARTICIPANT/PARENTAL INFORMED CONSENT SIGNATURE

- 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 Inspire Medical Group of California, PC 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(s)listed above.
- I acknowledge that: (a) I understand the purpose/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 on 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 my 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 law 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. Inspire Medical Group of California, PC or its affiliates may contact you, including by auto-dialed 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.

Signature of Patient (or parent / guardian): _____ **Date:** MONTH _____ DAY _____ YEAR _____

Print your Name: _____

SECTION 4: INSURANCE INFORMATION

INSURANCE PLAN/PLAN ID #: _____ **MEMBER/RECIPIENT ID #:** _____

GROUP NUMBER: _____ Insurance Company Phone Number: _____

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

_____

Medicare Number: _____ Last 4 digits of SSN (For insurance confirmation purposes only): _____

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SECTION 5: HEALTHCARE PROVIDER ONLY

Complete BEFORE vaccination administration

1. I have reviewed the **Patient Information and Screening Questions**	☐ YES ☐ NO
2. I have verified that this is the **vaccine requested** by the patient	☐ YES ☐ NO
3. This vaccine is appropriate for this patient based on the **Age Guidelines** provided by federal and/or state regulations and company policies	☐ YES ☐ NO
4. I have discussed with the patient additional immunizations the patient may be eligible for based on age and/or health conditions	☐ YES ☐ NO
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	☐ YES ☐ NO

For Shingrix®, MMR® II, Varivax®, YF-Vax®, Menveo®, Imovax®, Vaxchora®, and RabAvert®, ensure the vaccine is reconstituted following the package insert's instructions.

SECTION 6

Complete DURING the patient interaction

1. I have asked the patient to confirm their **Name, DOB, and Requested Vaccine** and verified it matched the information on the VAR form.	☐ YES ☐ NO
2. I have reviewed the **Screening Questions** with the patient	☐ YES ☐ NO
3. I have reviewed the **VIS/Patient Fact Sheet** with the patient	☐ YES ☐ NO

SECTION 7

Complete AFTER vaccine administration

Vaccine	Manufacturer	Dosage	Dosage # (if applicable)	Site of Administration	Vaccine Lot #	Vaccine Expiration	Diluent Lot # (if applicable)	Diluent Expiration (if applicable)

Clinician's Name (print): _____ **Clinician's Signature:** _____ **Title:** _____

If applicable, intern/tech name (print): _____ **Adminitration Date:** _____

Date EUA Fact Sheet/VIS given to patient: _____

NOTES

REMINDER

1. Update the patient's record with any new allergy, health condition, or primary care provider information

2. Enter vaccine lot #, expiration date and site of administration, then scan the VAR form into the patient's record.