Walgreens

Guide To Filling A LTCF VAR

Fill day of clinic or before clinic

Vaccine Administration Record (VAR)
Informed Consent for Vaccination in Long Term Care Facility (LTCF)

SECTION A-1

First Name: [First Name] **Last Name:** [Last Name]

Date of Birth: [Date of Birth] **Age:** [Age] **Gender:** ☐ Female ☐ Male **Phone:** [Phone]

LTCF Name: [LTCF Name] **Address:** [Address]

City: [City] **State:** [State] **Zipcode:** [Zipcode] **Email Address:** [Email Address]

I want to receive the following vaccination(s): COVID-19 Vaccination

Prior to the clinic, a LTCF can follow its standard process of obtaining consent

SECTION A-2 I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient, [illegible] 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 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 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, the federal Department of Health and Human Services, the Center for Disease Control and Prevention, 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, (b) the State HIE and/or State Registry from sharing my vaccination information with any of my other healthcare providers enrolled with 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 diseases (including HIV), and mental health information, to, or through, the State HIE or Government Agencies to my healthcare professionals, Medicare, Medicaid, or 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 when the applicable Provider invoices me after the time of service, upon receipt of such invoice. Walgreens may disclose your vaccination information for this visit for public health purposes and will send this information to the Medical Director or Administrator of the LTCF identified above. If you are an employee of the LTCF, Walgreens will send your vaccination information to your employer as required.

Walgreens or its affiliates may 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: [Print Name] **Patient/Authorized person signature:** _____

Patient, authorized person, or facility representative signature.

Fill day of clinic

SECTION B-1 SCREENING QUESTIONS. The following questions will help us determine your eligibility to be vaccinated today.

1. Do you feel sick today?	☐ Yes ☐ No ☐ I don't know
2. Do you have COVID-19?	☐ Yes ☐ No ☐ I don't know
3. Have you been treated with antibody therapy for COVID-19 (monoclonal antibodies or convalescent plasma)?	☐ Yes ☐ No ☐ I don't know
4. Do you have any health conditions, such as heart disease, diabetes, asthma, or are you immunocompromised? If yes, please list: _____	☐ Yes ☐ No ☐ I don't know
5. Do you have a history of anaphylaxis or have you ever had an allergy or reaction to vaccines, injectable therapy, or anything else (food, medicine, latex, polyethylene glycol, etc), including fainting or feeling dizzy? If yes, please provide details: _____	☐ Yes ☐ No ☐ I 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?	☐ Yes ☐ No ☐ I don't know
7. Have you received any vaccines in the last four weeks? If so, what and when? _____	☐ Yes ☐ No ☐ I don't know
8. **For women:** Are you pregnant or considering becoming pregnant in the next month?	☐ Yes ☐ No ☐ I don't know

SECTION B-2 I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient or representative of; or (c) a representative of the LTCF and, based upon clinical observation, have sufficient knowledge of the patient's condition to answer the Screening Questions. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.

Patient/LTCF Reprsentative: _____ **Date:** _____

Patient, authorized person, or facility representative signature.

Insurance and Medicare Cards

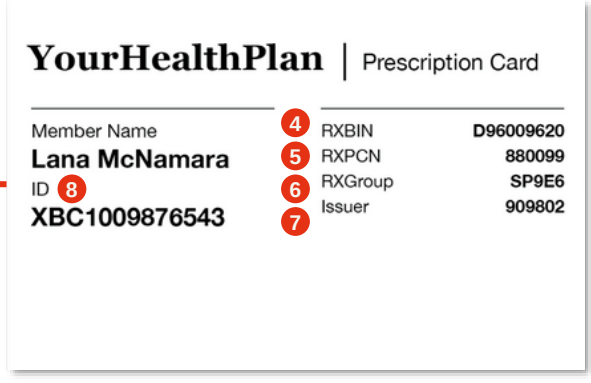
SECTION C — **INSURANCE – PATIENT TO COMPLETE IF APPLICABLE**

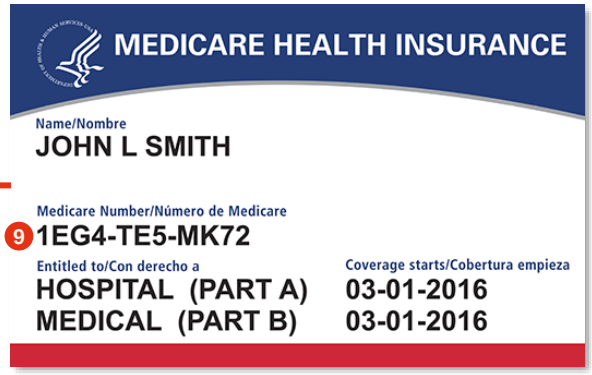
Please ensure to record BOTH pharmacy AND medical insurance information since there are multiple ways immunizations can be billed at Walgreens.

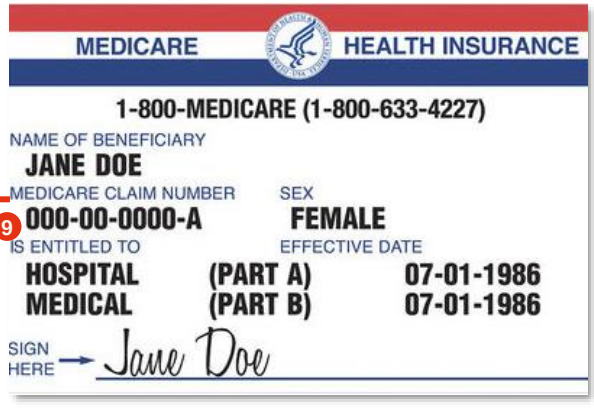
Non-Medicare:	Pharmacy Card	Medical Card
Insurance Plan/Plan ID:	7	1
Member/Recipient ID #:	8	2
RX BIN:	4	N/A
RX PCN:	5	N/A
Group Number:	6	3

Medicare:	Medicare Part B
Medicare Number*:	9

*Medicare Claim Number for cards distributed earlier than 2018.







For those covered by an insurance group or Medicaid

For those covered by Medicare Part B

Forms of Consent for Sections A-2 and B-2

For series COVID-19 vaccines, consent may be collected as outlined below. Consent may be collected for both dose 1 and dose 2 at the same time, but a separate VAR must be completed for each dose. Walgreens will distribute the Fact Sheet in advance of vaccines, so all residents and employees being vaccinated **fully understand what they are consenting to.**

In-Person	In writing by wet ink on the VAR form.
Phone	Walgreens Team Members must follow the LTCFs standard facility protocols for obtaining consent from family members or other authorized persons. When consent is received via phone, the Walgreens VAR form still needs to be signed by the facility personnel authorized to sign to indicate the consent was received verbally. The form indicates that an authorized person can complete the VAR on behalf of the patient.
Email/Fax	Team Members must follow the LTCFs standard facility protocols for obtaining consent from family members or other authorized persons. When consent is received via email, the Walgreens VAR form still needs to be signed by the facility personnel authorized to sign to indicate the consent was received verbally. The form indicates that an authorized person can complete the VAR on behalf of the patient.
Electronic Document Signature	Walgreens Team Members must follow the LTCFs standard facility protocols for obtaining consent from family members or other authorized persons. When consent is received via an electronic document system, the Walgreens VAR form still needs to be signed by the facility personnel authorized to sign to indicate the consent was received verbally. The form indicates that an authorized person can complete the VAR on behalf of the patient.