VACCINE ADMINISTRATION CONSENT FORM

Health Center_____

Name _____ **DOB** ____/____/____ **Age** _____ **ID#**_____

What Vaccine(s) are you requesting today: Check all that apply

☐ DTap ☐ Hepatitis A ☐ Hepatitis B ☐ Hib ☐ HPV ☐ Influenza ☐ IPV ☐ Meningococcal ☐ MMR
☐ Pneumococcal ☐ Rabies ☐ Rotavirus ☐ Shingles ☐ Td/Tdap ☐ TST ☐ Twinrix (Hep A/B)
☐ Typhoid (Inactivated) ☐ Yellow Fever ☐ Varicella ☐ Other_____

Please check YES or NO for each question	YES	NO
1. Are you 18 years of age or older?		
2. Do you have a cold, fever, or acute illness?		
3. Do you have any allergies to medication, food or any vaccine?		
4. Are you allergic to chicken eggs or egg products?		
5. Are you allergic to thimerosal (cleaning products or contact lens solution?		
6. Have you ever had a serious reaction after receiving a vaccine?		
7. Have you been diagnosed with Guillain-Barre syndrome?		
8. Do you have seizures, brain or nerve problems?		
9. Do you have a weakened immune system because of HIV/AIDS or other disease that affects the immune system, long term treatment with drugs such as steroids, or cancer treatment with radiation or drugs?		
10. Do you live with or expect to have close contact with a person whose immune system is severely compromised and who must be in a protective environment (such as a hospital room with reverse air flow)?		
11. Have you received a blood transfusion, blood product or immune gamma globulin in the past year?		
12. Have you received any vaccines in the past four weeks?		
13. Do you have any long-term health problems such as heart, lung, kidney, liver or metabolic disease such as diabetes, neurological or neuromuscular disease, anemia or any blood disorder?		
14. FOR WOMEN: Are you pregnant or is there a chance you could become pregnant in the next month?		

If you checked YES to any of the above, please explain here:

By signing below, I am consenting to the vaccine(s) listed, I have read or had explained to me the Vaccine Information Sheet known as VIS for each of the vaccine(s) I will receive today. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) as outlined on the VIS. I understand that the VIS contains a list of common adverse reactions and I can visit www.hrsa.gov/vaccinecompensation or call 1-800-338-2382 or call the Provider of the vaccine to report any adverse reaction. I can also visit www.cdc.gov/vaccines to learn more on how vaccines may protect my family and help prevent many diseases.

Name _____ Sign _____ Relationship to Patient_____ Date signed _____

*******CLINICAL STAFF USE ONLY*******

Vaccine Type	Vaccine			Date Given (M/D/Y)	Route	Site Given	Vaccine Information Sheet	
	Lot #	Expiration	Manufacturer				Date on VIS	Date Given

The above vaccine(s) and Vaccine Information Sheet(s) were administered /given by

*(Print Name/Signature)*_____