

CLIENT'S NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

I have read or have had explained to me the information contained in the appropriate Vaccine Information Statement about the disease(s) and vaccine(s) checked below. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and ask that the vaccine(s) indicated on this record be given to me or to the person named above for whom I am authorized to make this request.

SIGNATURE OF CLIENT/PARENT/GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

**DO NOT WRITE BELOW THIS LINE**

VACCINE	DATE GIVEN	MFG. LOT #	SITE OF INJ	SIDE EFF. STATED & VIS GIVEN	DATE OF VIS	ADMINISTERED BY
DTaP Pentacel Tdap Td					DTaP 5-17-07 Tdap 11-18-08 Td 11-18-08	
Hib titer PPD (TB Test) Rotavirus					HIB 12-16-98 Rotavirus 8-28-08	
Hepatitis B: Pediatric Adult Varivax HPV					HEPB 7-18-07 VARI 3-13-08 HPV 2-2-07	
Kinrix MMR Prevnar Pneumovax					MMR 3-13-08 PCV7 12-9-08 Pneum 4-16-09	
IPV Hep A Zostavax Menactra					IPV 1-1-00 HEPA 3-21-06 Menin 1-28-08	

PLEASE COMPLETE THE FOLLOWING TO HELP US DETERMINE IF THERE IS ANY REASON YOU/YOUR CHILD SHOULD NOT BE IMMUNIZED TODAY? FAMILY DOCTOR \_\_\_\_\_

	YES	NO	DON'T KNOW
IS THE PERSON RECEIVING THIS VACCINE:			
1. ALLERGIC TO ANY MEDICINE, EGGS, GELATIN OR LATEX? . . . . .	___	___	___
2. SICK WITH FEVER, VOMITING OR DIARRHEA? . . . . .	___	___	___
3. TAKING ANY MEDICINES OTHER THAN VITAMINS OR IRON? . . . . .	___	___	___
7. PREGNANT? . . . . .	___	___	___
8. IN CLOSE CONTACT WITH A PREGNANT FEMALE WHO HAS NEVER HAD CHICKENPOX? . . . . .	___	___	___
9. IN CLOSE CONTACT WITH AN INFANT WHOSE MOTHER HAS NEVER HAD CHICKENPOX? . . . . .	___	___	___
DOES THE PERSON RECEIVING THIS VACCINE:			
1. HAVE A CHRONIC ILLNESS OR BLOOD DISEASE? . . . . .	___	___	___
2. HAVE A POOR RESISTANCE TO INFECTION DUE TO DISEASE OR MEDICATION? . . . . . (I.E. ANTI-CANCER DRUGS: STEROIDS, CORTISONE OR X-RAY TREATMENT)	___	___	___
HAS THE PERSON RECEIVING THIS VACCINE:			
1. EVER HAD A SERIOUS REACTION TO ANY VACCINE? . . . . .	___	___	___
2. EVER HAD A CONVULSION, PARALYSIS, OR OTHER DISEASE OF THE NERVOUS SYSTEM? . . . . .	___	___	___
3. RECEIVED ANY SHOTS IN THE PAST 3 MONTHS? . . . . .	___	___	___
4. RECEIVED A TRANSFUSION OF BLOOD OR BLOOD PRODUCTS IN THE PAST 6 MONTHS? . . . . .	___	___	___
5. RECEIVED A TB SKIN TEST IN THE PAST 3 MONTHS OR HAVE ACTIVE TB? . . . . .	___	___	___
6. SEEN A PHYSICIAN WITHIN THE LAST YEAR? . . . . .	___	___	___
WHO AND FOR WHAT REASON? _____ WHEN _____			

I ACKNOWLEDGE THAT I RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICE.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

THIS RECORD CAN BE RELEASED UNTIL THE AGE OF 21 YEARS.