Vaccine Consent Form

Davies Clinic

Patient Name __________________________
Date of Birth ___________________________

	Yes	No
1. Have you had a fever in the last few days?		
2. Have you had a serious reaction to any vaccine in the past?		
3. Have you ever had a severe allergic reaction to gelatin (M,V,Y), neomycin (M,P,V, Y), polymyxin B or streptomycin (P), yeast (H, HPV), eggs (I), thimerosal (I), or latex (C)?		
4. Are you pregnant, breastfeeding or planning to become pregnant within the next 28 days (HPV, J, M, V Y)?		
5. Have you had a seizure in the past (MCV4, T)?		
6. Have you been diagnosed with cancer, leukemia, AIDS, or other immune system problem (M, R, V, Y)?		
7. In the last four weeks, have you taken cortisone, prednisone, or other steroids (M, R, V, Y)?		
8. Are you taking a medication that can weaken your immune system (such as Cytoxan, Enbrel, Humira, Methotrexate, or Remicade) (M, R, V, Y)?		
9. Have you had lymphoma, HIV, or been on chemotherapy or radiation therapy in the last 3 months (M, R, V, Y)?		
10. During the past year, have you received a transfusion or been given immune (gamma) globulin (M, V)?		
11. In the last four weeks, have you received any of the following vaccines: Measles, Mumps, Rubella, Varicella, or Yellow Fever? (M, V, Y)		

Patient's Statement

I have had the opportunity to review the VIS (vaccine information sheet) for the vaccines I am receiving today. I have had a chance to ask questions about the vaccine(s), including the risks, and benefits, and those questions were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) and consent to having the vaccine(s) given to me or to the person named above for whom I am authorized to give consent.

Sign here: ____ **Date:** ______________________

Vaccine Order:

Pediatrics: Bexsero, DTaP, Hib, Hep A, Hep B, HPV, Menactra, MMR, IPV, Tdap, Varivax

Influenza: ½ dose, Regular, High

Adult: Bexsero, Hep A, Hep B, HPV, Menactra, MMR, Prevnar, Pneumovax, Shingrix, Td, Tdap

2-4 month: Pediarix, Hib, Prevnar 13, Rotarix

6 month: Prevnar 13, Pediarix, Hib

12 month: ProQuad, Hep A, Hib, Prevnar 13

15 month: DTaP

18 month: Hep A

4 year: Kinrix, ProQuad

11 year: HPV, Menactra, Tdap

16 year: Menactra

Provider: __________________________**Date:** __________________

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Vaccines administered by: ______________________________

Date:________________________

Stickers from vaccines administered (indicate site vaccine was given):

Vaccine Footnotes:

C = consult package	**H** = Hepatitis B	**HPV** = Human Papillomavirus	**I** = Influenza	**M** = MMR/MMR-V
MCV4 = Meningococcal	**P** = Inactivated Polio	**R** = Rotavirus **T** = DTaP, Td, Tdap	**V** = Varicella (not Shingrix)	**Y** = Yellow Fever