VACCINE CONSENT FORM

I have been offered a copy of the Vaccine Information Statement(s) (VIS) checked below. I have read, had explained to me, and understand the information in the VIS(s). I ask that the vaccine(s) checked below be given to me or to the person named below for whom I am authorized to make this request.

VACCINE	X	VACCINE	X
DT—Diphtheria Toxoid		Meningococcal	
DTap—Diphtheria & Pertussis		MMR—Measles, Mumps, and Rubella	
Tdap—Diphtheria & Pertussis		PCV7/13--Pneumococcal	
Td—Diphtheria Toxoid		PPV23—Pneumococcal	
HepA—Hepatitis A		Varicella—Chickenpox	
HepB—Hepatitis B		Zoster—Shingles	
Hib—Haemophilus influenza Type B		Shingrix—Shingles	
HPV—Human papillomavirus		Other:	
Inactivated Influenza—Seasonal Flu Shot		Other:	

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Signature of Patient or Parent/Guardian
Date

PATIENT INFORMATION							
Last Name:	First Name:	Phone Number:	Age: Date of Birth:				
Address:	City:	State:	Zip Code:				
Primary Care Physician:	PCP Address:	PCP Phone Number:	PCP Fax:				

IMMUNIZATION SCREENING QUESTIONAIRE	YES	NO
1. Is the patient to be vaccinated currently sick or experiencing high fever?		
2. Does the patient have allergies to medications, food, a vaccine component, or latex?		
3. Has the patient had a serious reaction to a vaccine in the past?		

4. Does the patient have cancer, leukemia, HIV/AIDS, or any other immune system problem?		
5. In the past 3 months, has the patient taken any medications that weaken his/her immune system, such as, cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatment?		
6. Is the patient pregnant or is there a chance she could become pregnant during the next month?		
7. Has the patient received vaccinations in the past 4 weeks?		