Vaccine Administration Record/Informed Consent

Patient's Last Name_____ **First Name**_____ **Age:** _____

Language most comfortable speaking: _____ **Do you need an interpreter?** ☐ **Yes** ☐ **No**
Hearing impaired or need sign language interpreter services? ☐ **Yes** ☐ **No**
Did you bring your or your child's immunization record today? ☐ **Yes** ☐ **No**

PLEASE NOTE: It is important for you or your child to have a personal record of your vaccinations. If you do not have a record, ask your health care provider to give one to you. Make sure your health care provider records all your vaccinations. Bring this record with you every time you seek medical care.

I ACKNOWLEDGE THAT A COPY OF THE "NOTICE OF PRIVACY PRACTICE" HAS BEEN MADE AVAILABLE TO ME. _____ (INITIAL)

Patient Emergency Contact: (For emergency only such as passing out or needing to be taken to a hospital)
Name_____ **Relationship**: _____**Phone Number:** _____

SNHD STAFF ONLY VFC Eligibility
☐ Not Eligible ☐ No Insurance/Underinsured ☐ Native American or Alaskan Native ☐ NV Medicaid ☐ NV Check-Up

Complete the following questions to help us determine which vaccines may be given today.
If a question is not clear, please ask the nurse to explain it.

IS THE PERSON RECEIVING THE VACCINE:	**Yes**	**No**	**Don't Know**
1. Sick today?			
2. Allergic to latex, medications, food or any vaccine?			
3. Ever had a serious reaction after receiving a vaccine?			
4. Had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy?			
5. Between the ages of 2 and 4 years and had a healthcare provider tell you that the child had wheezing or asthma in the past 12 months?			
6. Been diagnosed with cancer, leukemia, AIDS, HIV or any other immune system problem?			
7. Taking cortisone, prednisone, other steroids, anticancer drugs or x-ray treatments?			
8. Been given a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin during the past year?			
9. Had a seizure or a brain problem?			
10. Received any vaccines or TB skin tests in the past 4 weeks or been told to get a TB skin test?			
FOR FEMALES 9 years old or older: Are you pregnant?			
Are you trying to get pregnant in the next 28 days?			
☐ Counseled to avoid pregnancy within the next 28 days: Nurse initial_____/Client initial_____			

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

SIGN HERE: _____**Date:** _____

☐ Client (18 years of age and older) ☐ Parent/Guardian

COMPLETE THE TOP PART ON THE BACK (NAME AND DATE OF BIRTH ONLY

Patient's Name_____ **Birth Date**_____
Last First Month Day Year

AREA BELOW FOR SNHD STAFF ONLY							
Vaccine	Date Given	Dose #	Mfg & Lot #	Site	Route	VIS Date	Administered by (Name/Title)
DTaP				LA RA LT RT	IM	04-01-20	
DT				LA RA LT RT	IM	04-01-20	
Td				LA RA LT RT	IM	04-01-20	
Tdap				LA RA LT RT	IM	04-01-20	
IPV				LA RA LT RT	IM SQ	10-30-19	
HIB				LA RA LT RT	IM	10-30-19	
MMR				LA RA LT RT	SQ	08-15-19	
Varicella				LA RA LT RT	SQ	08-15-19	
MMRV				LA RA LT RT	SQ	08-15-19	
Hep A				LA RA LT RT	IM	07-28-20	
Hep B				LA RA LT RT	IM	08-15-19	
Hep A-Hep B **Twinrix**				LA RA LT RT	IM	07-28-20 08-15-19	
MenACWY MenB				LA RA LT RT LA RA LT RT	IM IM	08-15-19 08-15-19	
PCV13				LA RA LT RT	IM	10-30-19	
DTaP-IPV				LA RA LT RT	IM	04-01-20 10-30-19	
DTaP-IPV/HIB **Pentacel**				LA RA LT RT	IM	04-01-20 10-30-19 10-30-19	
DTaP-IPV-Hep B **Pediarix**				LA RA LT RT	IM	04-01-20 10-30-19 08-15-19	
PPSV23 **Pneumovax**				LA RA LT RT	IM SQ	10-30-19	
Rabies				LA RA LT RT	IM	01-08-20	
Rotavirus				ORAL	PO	10-30-19	
Flu				LA RA LT RT	IM IN	08-15-19	
Shingles				LA RA LT RT	IM	10-30-19	
HPV				LA RA LT RT	IM	10-30-19	
Cholera				ORAL	PO	10-30-19	
Typhoid				LA RA	IM	10-30-19	
Yellow Fever				LA RA	SQ	04-01-20	
Japanese Enceph				LA RA LT RT	IM	8-15-19	
NB Screening							
Multi-Vaccine VIS						04-01-20	

Record # _____ Return Date:_____ VIS Given: Clerk _____ Clinician_____

Reviewed by:_____ RN / LPN Date: _____

Clinic Location: ☐Main ☐ELV ☐Hend ☐Mesquite ☐ Mobile Unit ☐Employee Health ☐Other _____