

**VACCINE CONSENT FORM**

|                 |                                 |  |  |  |
|-----------------|---------------------------------|--|--|--|
| NAME (Last)     | (First)                         | (M.I.)   | Date of Birth<br>____/____/____<br><i>month day year</i> |  |
| Mailing Address |                                 | Gender<br><input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Prefer Not to Say |  |  |
| City            | State                           |  | Zip  |  |
| Phone           | Insurance Name -<br>ID Number - |  |  |  |

|   |     |    |     |
|---|-----|----|-----|
| The following questions will help us determine your eligibility to be vaccinated today.   | Yes | No | N/A |
| 1. Which vaccines is patient requesting today? Please list all requested vaccines:<br><input type="checkbox"/> Flu Shot <input type="checkbox"/> Pneumonia <input type="checkbox"/> Shingles <input type="checkbox"/> Other (Name of Vaccine) - |     |    |     |
| 2. Has the Patient had a fever greater than 101F within the past 24 hours?  |     |    |     |
| 3. Does the patient have allergies to medications, food, a vaccine component, eggs, or latex?<br>If yes, please explain:  |     |    |     |
| 4. Has the patient had a seizure, encephalopathy or Guillain-Barre syndrome?  |     |    |     |
| 5. Does the patient have cancer, leukemia, HIV/AIDS or any other immune system problem?   |     |    |     |
| 6. Has the patient received any vaccine in the last 1 month?  |     |    |     |
| 7. Has the patient received a transfusion of blood or been given immune globulin in the past 1 year?  |     |    |     |
| 8. Is the patient pregnant or is there a chance she could become pregnant in next 1 month?  |     |    |     |
| 9. In the past 3 months, has the patient currently receiving radiation, chemotherapy, or immunosuppressive therapy?   |     |    |     |
| 10. Has the patient had serious reaction or dizziness or fainting episode during or after immunization?   |     |    |     |

I certify that I am: (i) the patient and at least 18 years of age (ii) the parent or legal guardian of the minor patient. I have read or had explained to me the Vaccine Information Statement about my vaccination. I have had a chance to ask questions, which were answered to my satisfaction, and I understand the benefits and risks of the vaccination as described. I request that the vaccination be given to me (or the person named above for whom I am authorized to make this request). I authorize the release of any medical or other information necessary to process a Medicare or other insurance claim or for other public health purpose.

\_\_\_\_\_  
Signature of Recipient Or (Parent of Guardian)

\_\_\_\_\_  
Date

**For Office USE ONLY**

| Date Given | Manufacturer/ Lot No. | Exp. Date | Site (circle) | Route | Administered By: |
|------------|-----------------------|-----------|---------------|-------|------------------|
|            |                       |           | LD    RD      | IM    |                  |