

Write or stamp clinic address here

## Patient Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Age: \_\_\_\_ years: \_\_\_\_ months (if under age 5) Gender: Male \_\_\_\_ Female \_\_\_\_  
 Address: \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Mother's Maiden Name (optional): \_\_\_\_\_  
 Race: American Indian/Alaskan Native Asian White Decline to Answer  
(Circle all that apply) African American Native Hawaiian/Pacific Islander  
 Ethnicity: Hispanic? Yes \_\_\_\_ No \_\_\_\_ Decline \_\_\_\_\_ Primary Language: \_\_\_\_\_  
 Social Security Number (optional): \_\_\_\_\_ — \_\_\_\_\_ — \_\_\_\_\_ Medicaid ID Number (optional): \_\_\_\_\_

I have received this clinic's HIPAA Notice of Privacy Practices

## Patient Screening Questions

	Circle one:	
	Yes	No
Does the patient have a fever or feel sick today?	Yes	No
Does the patient have allergies to medicines, food, latex or vaccines?	Yes	No
Has the patient had a bad reaction to a vaccination?	Yes	No
Has the patient had a seizure or a brain problem?	Yes	No
Does the patient have cancer, leukemia, AIDS or other immune system problem?	Yes	No
Does the patient have heart disease, lung disease, kidney disease, diabetes, asthma, anemia or other long term condition?	Yes	No
Has the patient taken cortisone, prednisone, other steroids or cancer treatments in the last 3 months?	Yes	No
Has the patient received blood, blood products or immune globulin (IG) in the past year?	Yes	No
Is the patient pregnant or planning to become pregnant?	Yes	No
Has the patient received vaccines in the past month?	Yes	No
Has the patient ever fainted after injections?	Yes	No
Has the patient had chicken pox?	Yes	No
If yes, when (estimated date): _____		

I have received the Vaccine Information Statement(s) for the vaccines to be given and I have had all of my questions answered. I request that the vaccine be given to me or to the person named above, for whom I am responsible. I allow the release of any information needed to process insurance claims and request payments of medical benefits.

Print name: \_\_\_\_\_  
 Signature: \_\_\_\_\_  
 Relationship to patient: \_\_\_\_\_  
 Date: \_\_\_\_\_

Dose #	Vaccine	Brand Name	Lot Number	Exp.	Manuf.	Dose (ML)	Site/Rte	Elig.	VIS Pub Date	Date VIS Given
	DTaP	Infanrix Tripedia Daptacel			GSK Sanofi Sanofi	0.5				
	DTaP/Hep.B/IPV	Pediarix			GSK	0.5				
	DTaP/Hib/IPV	Pentacel			Sanofi	0.5				
	DTaP/IPV	Kinrix			GSK	0.5				
	Hep. A	Vaqta (peds/adult) Havrix (peds/adult)			Merck GSK	0.5 1.0				
	Hep. A – Hep. B	Twinrix			GSK	1.0				
	Hep. B	Recomb. (peds/adult) Engerix (peds/adult)			Merck GSK	0.5 1.0				
	Hib	ActHib Hiberix PedVax			Sanofi GSK Merck	0.5				
	Hib-Hep. B	Comvax			Merck	0.5				
	HPV	Gardasil Cervarix			Merck GSK	0.5				
	Influenza live	Flumist (3 or 4)			MedImm	0.2				
	Influenza split					0.25 0.5				
	IPV	IPOL			Sanofi	0.5				
	MCV4	Menactra Menveo			Sanofi Novartis	0.5				
	MCV2	MenHibrix			GSK	0.5				
	MPSV4	Menomune			Sanofi	0.5				
	MMR	MMR II			Merck	0.5				
	MMRV	ProQuad			Merck	0.5				
	PCV13	Prevnar 13			Wyeth	0.5				
	PPV23	Pneumovax			Merck	0.5				
	Rotavirus	Rotarix RotaTeq			GSK Merck	1.0 2.0				
	Tdap	Boostrix Adacel			GSK Sanofi	0.5				
	Td	Decavac Tenivac			Sanofi	0.5				
	Varicella	Varivax			Merck	0.5				
	Zoster	Zostavax			Merck	0.65				
	Other									

PPD Test	Reason Given Code	Lot # and Manufacturer	Inject. Code	MM Results	Date Read	Time Read	Read By

Vaccine Administrator Signature: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_

Vaccine Administrator Signature\*: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_

\*Use this 2<sup>nd</sup> signature line if more than one person gave immunizations to client.