

**Community Health Care**

**Immunization Consent and Questionnaire**

DOB: \_\_\_\_\_ Name: \_\_\_\_\_  Male  Female

Parent Name: \_\_\_\_\_

Immunizations to be given today:

- |                                    |                                    |  |   |  |
|------------------------------------|------------------------------------|--|---|--|
| <input type="checkbox"/> Pediarix® | <input type="checkbox"/> Pentacel® | <input type="checkbox"/> Rotavirus     | <input type="checkbox"/> Hep B            | <input type="checkbox"/> DTaP                |
| <input type="checkbox"/> Hib       | <input type="checkbox"/> IPV       | <input type="checkbox"/> MMR           | <input type="checkbox"/> Varicella        | <input type="checkbox"/> ProQuad®            |
| <input type="checkbox"/> Hep A     | <input type="checkbox"/> PCV13     | <input type="checkbox"/> Meningococcal | <input type="checkbox"/> Tdap             | <input type="checkbox"/> HPV                 |
| <input type="checkbox"/> Influenza | <input type="checkbox"/> PPSV      | <input type="checkbox"/> Td            | <input type="checkbox"/> Twinrix®/Kinrix® | <input type="checkbox"/> Zostavax®/Shingrix® |

**Immunization Screening Questionnaire**

The following questions will help us determine which vaccines you (or your child) may be given today. If you answer "yes" to a question, it does not necessarily mean that you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

- |   |  |
|---|--|
| 1. Does the person getting immunized have a fever greater than 101° today?  | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know |
| 2. Does the person have serious allergies or reactions to any foods, vaccine or vaccine ingredients (especially eggs or latex)?   | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know |
| 3. Has the person had a health problem with lung, heart, kidney or metabolic disease (like diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy?                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know |
| 4. Has the person had seizures, brain or other neurological problems such as Guillain-Barré syndrome? Has a close relative had any of these problems?   | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know |
| 5. Does the person have cancer, a blood disorder, leukemia, AIDS, or any other immune system problem, or any other chronic diseases to include asthma or conditions that have required the use of an inhaler? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know |
| 6. Does anyone who lives with or takes care of the person have any immune system problems?  | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know |
| 7. Has the person received vaccinations in the past 4 weeks?<br><i>(If yes, please review with nursing staff.)</i>  | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know |
| 8. <b>Women only:</b> Is there a possibility of pregnancy?<br><i>(If yes, do not give live virus vaccine.)</i>  | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know |

By signing below, I consent to have these immunizations given to my child/me. I have received a written version of current Vaccine Information Statements (VIS). I acknowledge that I have read/had explained to me the information about the diseases and vaccines marked above. I have had a chance to ask questions that were answered to my satisfaction, and I understand the risks and benefits involved. I understand this immunization information may be entered into an electronic database that can be shared with other providers.

**For teens:** I understand that adverse (bad) effects are rare, but that if I have an allergic reaction, my parent(s) will need to be contacted.

\_\_\_\_\_  
**Patient signature (if 14 or older)** \_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Parent/guardian signature (if patient under 18)** \_\_\_\_\_  
**Date**

**Questionnaire and CHILD PROFILE reviewed by: (medical staff)**

\_\_\_\_\_  
**Staff signature/title** \_\_\_\_\_  
**Date**

MR # \_\_\_\_\_

### Pediatric Immunization Details

Brand Name	Vaccine Type	Lot #	Exp. Date	Site	Route	Manufacturer	Dose	Diluent Lot #	Diluent Exp. Date
Pediarix	Dtap-Hep B-IPV				IM	GlaxoSmithKline	0.5ml		
Pentacel	Dtap-HIB-IPV				IM	Sanofi Pasteur	0.5ml	Has own diluent	
Engerix-B	Hep B				IM	GlaxoSmithKline	0.5ml		
ActHIB	HIB-PRP-T				IM	Sanofi Pasteur	0.5ml	Has own diluent	
Prevnar13	PCV-13				IM	Pfizer	0.5ml		
Rotateq	Rotavirus				Oral	Merck	2ml		
Havrix	Hep A				IM	GlaxoSmithKline	0.5ml		
I POL	Polio IPV				IM/SQ	Sanofi Pasteur	0.5ml		
MMRII	MMR				SQ	Merck	0.5ml		
Varivax	Varicella				SQ	Merck	0.5ml		
Proquad	MMR Varicella				SQ	Merck	0.5ml		
Daptacel	Dtap				IM	Sanofi Pasteur	0.5ml		
Kinrix	Dtap-IPV				IM	GlaxoSmithKline	0.5ml		
Gardasil 9	HPV				IM	Merck	0.5ml		
Menactra	MCV4P				IM	Sanofi Pasteur	0.5ml		
Adacel	Tdap				IM	Sanofi Pasteur	0.5ml		
Tenivac	Td				IM	Sanofi Pasteur	0.5ml		
	Influenza				IM				

### Adult Immunization Details

Pneumovax	PPSV23				IM/SQ	Merck	0.5ml		
Zostavax	Zoster				SQ	Merck	0.5ml		
Prevnar13	PCV-13				IM	Pfizer	0.5ml		
	Influenza				IM		0.5ml		