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Vaccine Consent/ Responsibility/ Authorization

Printed Patient Name: ____

Patient DOB: ____________________Date: ___________________MA Initials: ________________

Vaccine Information:

1) Today you are receiving the vaccination: _________________________**Manufacturer:** ___________

1) Lot Number: _______________________ Vaccine Expiration Date: ________________

2) Today you are receiving the vaccination: _________________________Manufacturer: ___________

2) Lot Number: _______________________ Vaccine Expiration Date: ________________

3) Today you are receiving the vaccination: _________________________Manufacturer: ___________

3) Lot Number: _______________________ Vaccine Expiration Date: ________________

The vaccine may be a **single dose** or require **multiple doses** over the course of the next 3 to 6 months. Please make sure that you understand the requirements of the particular vaccine you are receiving today before you leave the office.
The Adult **Hepatitis B** and **Cervarix** vaccines are given in three (3) doses over the course of six months. Your schedule should adhere to the following interval.

First dose: _______________Second dose: ______________Third dose: _______________

Today **1 month** **6 months**

The **Gardasil** vaccine is given in three (3) doses over the course of six months. Your schedule should adhere to the following interval.

First dose: _______________Second dose: ______________Third dose: _______________

Today **2 months** **6 months**

I have read the patient information sheet and would like to receive this vaccination. If the costs of the vaccine, and/or with any administration fees, are not covered by my Health Insurance Company, I and/or my parent/guardian agree to pay for the full price of the vaccine and its administration at the time of the first dose. I understand that if the intended recipient of the HPV vaccination is outside of the ages 9-26 years old, it is unlikely that any insurance will cover the cost of either fee.

____

Patient/Parent/Guardian/Responsible Party Date

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Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME ______________________________

DATE OF BIRTH ____/____/____ (month / day / year)

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means we need to ask you more questions. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Are you sick today?	☐	☐	☐
2. Do you have allergies to medications, food, a vaccine ingredient, or latex?	☐	☐	☐
3. Have you ever had a serious reaction after receiving a vaccine?	☐	☐	☐
4. Do you have a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood clotting disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Are you on long-term aspirin therapy?	☐	☐	☐
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
6. Do you have a parent, brother, or sister with an immune system problem?	☐	☐	☐
7. In the past 3 months, have you taken medicines that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?	☐	☐	☐
8. Have you had a seizure or a brain or other nervous system problem?	☐	☐	☐
9. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
10. Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
11. Have you received any vaccinations in the past 4 weeks?	☐	☐	☐

FORM COMPLETED BY ______________________________ DATE__________

FORM REVIEWED BY ______________________________ DATE__________

Did you bring your immunization record card with you? yes ☐ no ☐

It is important for you to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.