ADULT CONSENT FOR VACCINE ADMINISTRATION

PLEASE READ AND COMPLETE THE FOLLOWING INFORMATION TO RECEIVE IMMUNIZATIONS

Name: _____ Date of Birth: _____/ _____ / _____
(Last) (First) (MI)

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____/ _____ School/Location: _____
(Home) (Work)

I have read and understand the information contained on this form. I believe I understand the benefits and risks of the vaccination(s). I request the identified vaccine(s) to be given to me. I have no conditions, which are contraindications for vaccination. I certify that the information I provided is true and accurate. If under 18, parent/guardian signature required.

Signature:_____ Date: _____

TO RECEIVE VACCINATIONS THE CLIENT MUST MEET THE FOLLOWING REQUIREMENTS:

ADMINISTERING NURSE: _____ DATE SHOTS GIVEN:_____

☐ INFLUENZA VACCINE:

The client is/has:
NOT allergic to eggs or egg products. NOT ever had a serious allergic reaction after getting a flu vaccination. NOT ever been paralyzed by Guillain-Barre Syndrome. NOT moderately or severely ill.

Manufacturer: _____
Lot No. _____
Dosage: 0.5 cc Route: IM
Site: ☐ Right Arm ☐ Left Arm

☐ TETANUS AND DIPHTHERIA AND PERTUSSIS VACCINE (Td) (Tdap)

The client is/has:
NEVER had a serious allergic reaction or other problem with Td, or Tdap. NOT moderately or severely ill.
NOT pregnant. NEVER had a fever (105) within 48 hrs. after vaccination with a prior Td/Tdap dose. NEVER had a seizure within 3 days of receiving a prior Td/Tdap dose. NEVER had a collapse or shock-like state within 48 hrs. of receiving a Td/Tdap dose. NOT had a Td/Tdap within the last 10 years.

Manufacturer: _____
Lot No. _____
Dosage: 0.5 cc Route: IM
Site: ☐ Right Arm ☐ Left Arm

☐PNEUMOCOCCAL VACCINE

The client is/has:
NOT pregnant. NOT received a pneumonia vaccine within the past six years. NOT presently sick with a fever. NOT taken an antibiotic within the past 48 hrs. (except for prophylactic antibiotics). NOT allergic to Thimerosal (a Mercury based preservative)

Manufacturer: _____
Lot No. _____
Dosage: 0.5 cc Route: IM
Site: ☐ Right Arm ☐ Left Arm

☐ HEPATITIS A

The client is/has:
NOT pregnant. NOT moderately or severely ill. NOT had a serious allergic reaction to a previous dose of Hepatitis A.

☐ 1st Dose _____ (Date)
☐ 2nd Dose _____ (Date) >6mos

Manufacturer: _____
Lot No. _____
Dosage: 1.0 cc Route: IM
Site: ☐ Right Arm ☐ Left Arm

Manufacturer: _____
Lot No. _____
Dosage: 1.0 cc Route: IM
Site: ☐ Right Arm ☐ Left Arm

☐ HEPATITIS B

The client is/has:
NOT breastfeeding or pregnant. NOT allergic to yeast. NOT sensitive to Mercury (Thimerosal). NOT moderately or severely ill. NOT had an allergic reaction to a previous dose of Hepatitis B.

Manufacturer: _____
Lot No. _____
Dosage: 1.0 cc Route: IM
Site: ☐ Right Arm ☐ Left Arm

Manufacturer: _____
Lot No. _____
Dosage: 1.0 cc Route: IM
Site: ☐ Right Arm ☐ Left Arm

Manufacturer: _____
Lot No. _____
Dosage: 1.0 cc Route: IM
Site: ☐ Right Arm ☐ Left Arm

☐ 1st Dose _____ (Date)
☐ 2nd Dose _____ (Date) >1 mo.
☐ 3rd Dose _____ (Date) > 5mos after 2nd dose

☐ TWINRIX

Please see above Hepatitis A & B requirements. Dosing schedule the same as Hepatitis B.

Manufacturer: _____
Lot No. _____
Dosage: 1.0 cc Route: IM
Site: ☐ Right Arm ☐ Left Arm

Manufacturer: _____
Lot No. _____
Dosage: 1.0 cc Route: IM
Site: ☐ Right Arm ☐ Left Arm

Manufacturer: _____
Lot No. _____
Dosage: 1.0 cc Route: IM
Site: ☐ Right Arm ☐ Left Arm

☐ 1st Dose _____ (Date)
☐ 2nd Dose _____ (Date) >1 mo.
☐ 3rd Dose _____ (Date) > 5mos after 2nd dose