Immunization Questionnaire and Consent Form

	Yes	No	Don't Know
1. Are you sick today?			
2. Do you have allergies to medications, food, or any vaccine?			
3. Have you ever had a serious reaction after receiving a vaccination?			
4. Do you have cancer, leukemia, AIDS, or any other immune system problem?			
5. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had x-ray treatments?			
6. Do you have a seizure or a brain problem?			
7. During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin?			
8. Women: Are you pregnant or is there a chance you could become pregnant during the next month?			
9. Have you received any vaccinations in the past 4 weeks?			

Your signature below indicates that you have read and understand the Vaccination Information Statement provided, you have truthfully answered the questions above, and you agree to the administration of the vaccination.

Name (Print): _____

Address: _____

Date of Birth: _____ Today's Date: _____

Signature: _____

For Pharmacist Use ONLY

Vaccine	Mfr.	Lot#	Exp. Date	Route	Site	Dose

Amount of time the patient remained for observation: _____

Prescribing Physician (For High Risk Adults): _____

OR

Prescribing Pharmacist's Name (Printed): _____

Signature: _____

AND

Administering Pharmacist's Name (Printed): _____

Signature: _____

In the space provided below attach prescription label for each vaccination