Jefferson County Public Health – Immunization Consent

Patient _____
(Mr./Ms.) First Name MI Last Name

Birth Date ____/_____/____ Age _____ Gender _____ Marital Status: Single Married Divorced

_____ ____/_____/_____
❖ If under 18, PRINTED name of Parent or Guardian Parent/Guardian birth date
(Parent or Guardian must authorize immunization on reverse side for a patient under age 18)

Mailing address:_____
Street City State Zip Code

Phone # (_____)_____ email address:_____

Race:

☐ American Indian or Alaskan Native ☐ Asian
☐ Black or African American ☐ Native Hawaiian or other Pacific Islander
☐ White or Caucasian ☐ Other Race: _____

Hispanic? Y / N

Has the patient:

Yes	No	Unsure	
☐	☐	☐	Experienced fever, vomiting, or diarrhea today?
☐	☐	☐	Received any other immunizations during the past month?
☐	☐	☐	Had allergies to medications, eggs, yeast, gelatin, latex, or other foods or chemicals? List:_____
☐	☐	☐	Had a serious reaction or allergy to a vaccine in the past?
☐	☐	☐	Had the chickenpox? Approximate date or age of disease: _____
☐	☐	☐	Does the patient or a family member have seizures, changing neurological disorder, or Guillain-Barre syndrome?
☐	☐	☐	Ever had thrombocytopenia (decreased platelets/increase bleeding)?
☐	☐	☐	Received blood, plasma, or immune globulin in the past six months?
☐	☐	☐	Have a bleeding disorder or take medications that increased bleeding?
☐	☐	☐	Are you pregnant or planning to be pregnant within the next month?
☐	☐	☐	Had a history of thymus disease, thymectomy, or intussusception?
☐	☐	☐	Does the patient or anyone in the home have: cancer, an immune disorder, a spleen removed, an organ transplant, or being treated with medications for rheumatoid, psoriasis, or autoimmune disease, or medications that suppress the immune system? Is the patient or anyone at home HIV positive?

JEFFERSON COUNTY PUBLIC HEALTH • 615 SHERIDAN • PORT TOWNSEND, WA 98368 **NAME**_____

✓ VIS GIVEN	VACCINE	DOSE #-	MANUFACTURER & LOT NUMBER	ROUTE/ & SITE	DOSE	VACCINE INFORMATION STATEMENT (VIS)
	DIPHTHERIA,/TETANUS/PERTUSSIS DtaP _____ DT _____ 2 mo – 6 yrs.	1, 2, 3 4, 5	GSK SANOFI	IM:_____	0.5 cc	DIPHTHERIA, TETANUS & PERTUSSIS 5/17/07
	TETANUS/DIPHTHERIA,/PERTUSSIS Tdap_____ Td_____ **State**_____ **Private**_____ 7-18 yrs / 11-18 yrs. 19+ yrs.	1, 2, 3, 4, 5	GSK SANOFI	IM:_____	0.5 cc	TETANUS, DIPHTHERIA 2/24/15 TETANUS/DIPHTHERIA,/PERTUSSIS 2/24/15
	PEDIARIX____ PENTACEL____ DTaP + IPV DTaP + IPV + HEP B 2 mo – 6 yrs + HIB	1, 2, 3	GSK SANOFI	IM:_____	0.5 cc	DIPHTHERIA, TETANUS & PERTUSSIS 5/17/07 + POLIO 7/20/16 + HEPATITIS B 7/20/16 **OR** HIB 4/2/15
	POLIO VACCINE - IPV **State**_____ **Private**_____ 2-18 yrs 19+ yrs	1, 2, 3, 4	SANOFI	IM:_____ SC:_____	0.5 cc	POLIO 7/20/16
	HAEMOPHILUS b CONJUGATE HIB 2 mo – 4 yrs.	1, 2 3, 4	MERCK SANOFI	IM:_____	0.5 cc	HAEMOPHILUS b CONJUGATE 4/2/15
	PNEUMOCOCCAL CONJUGATE PCV13 2 mo – 5yrs.	1, 2, 3, 4	PFIZER	IM:_____	0.5 cc	PNEUMOCOCCAL CONJUGATE 11/5/15
	ROTAVIRUS **6 - 32 WEEKS ONLY** (1st Dose 6 - 12 WEEKS ONLY)	1, 2, 3	MERCK	ORAL:___		ROTAVIRUS 4/15/15
	HEPATITIS **B** **State**_____ **Private**_____ 0-19 yrs 20+ yrs	1, 2, 3	GSK MERCK	IM:_____	0-10 yrs. 0.5 cc 11-19 yrs. 0.5 cc 20+ yrs. 1 cc	HEPATITIS B 7/20/16
	HEPATITIS **A** **State**_____ **Private**_____ 2-18 yrs 19+ yrs	1, 2, 3	GSK MERCK	IM:_____	2-18 yrs. 0.5 cc 19+ yrs. 1 cc	HEPATITIS A 7/20/16
	MEASLES-MUMPS-RUBELLA **State**_____ **Private**_____	1, 2	MERCK	SC:_____	0.5 cc	MEASLES, MUMPS, RUBELLA 4/20/12
	VARICELLA **State**_____ **Private**_____ 2-18 yrs 19+ yrs	1, 2	MERCK	SC:_____	0.5 cc	MMRV 5/21/10 VARICELLA 3/13/08
	HUMAN PAPILLOMAVIRUS **State**_____ **Private**_____ 9 - 18yrs 19 - 26 yrs.	1, 2, 3	MERCK	IM:_____	0.5cc	HUMAN PAPILLOMAVIRUS 3/31/16
	MENACTRA - MENINGOCOCCAL **State**_____ **Private**_____ 11-18 yrs 19-55 yrs.		SANOFI	IM:_____	0.5 cc	MENINGOCOCCAL VACCINES 3/31/16
	INFLUENZA **State**_____ **Private**_____ 6 mo – 18 yrs 19+ yrs	1, 2	MEDIM SANOFI	IM:_____ NAS:____	0.5 cc 0.25 cc 0.2 cc	INFLUENZA VACCINES 8/7/15
	PNEUMOCOCCAL 2 yrs – Adult	1, 2	MERCK	IM:_____ SC:_____	0.5 cc	PNEUMOCOCCAL VACCINE 4/24/15
	YELLOW FEVER	1, 2	SANOFI	SC:_____	0.5 cc	YELLOW FEVER 3/30/11
	MENOMUNE - MENINGOCOCCAL 2 yrs – Adult		SANOFI	SC:_____		MENINGOCOCCAL VACCINE 10/14/11
	TYPHOID ORAL _____ INJECTABLE_____		CRUCELL SANOFI	ORAL:___ IM:_____	4 capsules 0.5 cc	TYPHOID VACCINES 5/29/12
	RABIES INTRAMUSCULAR	1, 2, 3 4, 5	CHIRON SANOFI	IM:_____	1.0 cc	RABIES 10/6/09
	JAPANESE ENCEPHALITIS	1, 2	INTERCELL	IM:_____	IXARIO 0.5cc	JAPANESE ENCEPHALITIS 1/24/14

I have been given a copy and have read or had explained to me information in the Vaccine Information Statements for the diseases and the vaccines checked above. I had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits & risks of the vaccines and request that the vaccines indicated above be given to me or the person named on the reverse side for whom I am authorized to make this request.

_____ _____

SIGNATURE OF PERSON TO RECEIVE VACCINE (OR PARENT / GUARDIAN IF UNDER 18) **DATE**

SPECIAL CIRCUMSTANCES ONLY I authorize_____ to accompany my child for the immunizations checked above. Signature of Parent or Guardian _____

CHART NOTES: ☐ **Assessed client's immunization history. Counseled about recommended vaccines to be administered.**

_____

_____

SIGNATURE AND TITLE OF VACCINE ADMINISTRATOR **DATE**

updated 8- 2016