VALLEY MEDICAL PRIMARY CARE, INC

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VACCINE DOCUMENTATION AND CONSENT FORM

DTP	☐	OPV	☐	Hepatitis A	☐	Pneumovax	☐
DtaP	☐	H1B	☐	Hepatitis B	☐	Shingles	☐
Td (Adult)	☐	Varicella	☐	MMR	☐	Influenza	☐

NAME (Last)	(First)	(Middle)
BIRTH DATE	AGE	GENDER M / F
PHONE		
ADDRESS	CITY	STATE ZIP
RACE White __ Black __ Asian __ Caucasian __ Other __	ETHNICITY Hispanic ___ Non-Hispanic ___	MARITAL STATUS Married __ Single __ Widowed __ Divorced __
DOCTOR'S NAME		

IMMUNIZATION SCREENING QUESTIONNAIRE	
1. Is the person to be vaccinated sick today or experiencing a fever? If YES, describe illness.	___ Yes ___ No
2. Has the person to be vaccinated ever had an allergy to any **food, medication** or **vaccine** that produced a life-threatening reaction? If yes, what:	___ Yes ___ No
3. Does the person to be vaccinated have a severely weakened immune system due to illness or is the person currently receiving cancer treatments with radiation or drugs?	___ Yes ___ No
4. Has the person to be vaccinated received a gamma globulin (Immune Globulin) injection or received blood products such as platelets, factor 8, plasma or whole blood in the last 12 months?	___ Yes ___ No
5. Has the person to be vaccinated taken any immune suppressing or antiviral medicines in the last seven days like: (methotrexate, prednisone, tamiflu) or **For Children and Teens**: Do they take a daily aspirin?	___ Yes ___ No
6. Does the person to be vaccinated have any long term health problems: Autoimmune Disorders (Lupus, RA), lung (Asthma/Wheezing/Reactive Airway), diabetes, heart, kidney, liver disease or anemia? Circle which applies.	___ Yes ___ No
7. Does the person to be vaccinated have a history of Convulsions or other neurological problems, or a history of low platelet count?	___ Yes ___ No
8. Has the person to be vaccinated received any vaccinations within the last 28 days? If yes, what:	___ Yes ___ No
9. Has the person to be vaccinated ever had Guillain-Barre' Syndrome? (a rapid progressive loss of sensation from the toes upward)	___ Yes ___ No
10. For Females: Is the person to be vaccinated currently pregnant or planning to become pregnant within the next three months?	___ Yes ___ No
11. For Flu Season – Has the person to be vaccinated ever had any Pneumonia "Pneumococcal" vaccine?	___ Yes ___ No

I have been offered or provided, whether accepted or not, a copy of the "Vaccine Information Statement (VIS)" checked below. I have read, or have had explained to me the information on the VIS(s). My questions have been answered satisfactorily, and I ask that the vaccine(s) checked above be given to me or to the person named below for whom I am authorized to make the request. As a patient/guardian, I understand I will be responsible to pay for any services the insurance does not cover.

_____ _____

Signature of Patient/Gaurdian Date