_____Initial visit for VFC vaccination-2004

_____Return visit for VFC vaccination-2004

VACCINE DOCUMENTATION/CONSENT FORM

I have been offered or provided, whether accepted or not, a copy of the "Vaccine Information Statement(s)" checked below. I have read, or have had explained to me, the information in the "Vaccine Information Statement(s)". My questions have been answered satisfactorily, and I ask that the vaccine(s) checked below be given to me or to the person named below for whom I am authorized to make this request:

9DTaP **9**DT **9**Td **9**DTaP/Hib **9**Hib **9**Hib/HepB **9**HepB **9**HBIG **9**HepA **9**EIPV
9MMR **9**Varicella **9** PCV7 **9**Influenza **9**PPV23 **9**DTaP/HepB/EIPV **9**Other_____

_____ _____
Signature of Patient or Parent/Guardian Date

PATIENT INFORMATION				
Patient's Last Name: **Patient's First Name:**		**Phone Number:**	**Age:**	**Birth date:**
Street Address:	**City:**	**County:**	**State:**	**Zip Code:**
Ethnicity: Hispanic or Latino ___ Yes ___ No **Gender** ___ Male ___ Female	**Race:** (Select one or more.) ___ AS-Asian/Pacific Islander/Other ___ HA-Hawaiian ___ BL-Black or African American ___ IN-Native American/Alaska Native ___ CA-Caucasian/Mexican/Puerto Rican ___ JA-Japanese ___ CH-Chinese ___ NW-Other Non-White ___ FI-Filipino ___ UN-Unknown			
Primary Care Physician:	**Street Address:** **City:**	**State:** **Zip:**	**Phone:** **Fax:**	

PATIENT ELIGIBILITY							
__Medicaid	__No health insurance	__Native Am/Alaska Native	__Underinsured*^	__Underserved**^	__HealthWave	__Fully Insured	

*Underinsured children: insurance does not cover immunizations, are eligible through VFC program if vaccinated at a FQHC or RHC.
**Underserved children: children have insurance co-pay or deductible high enough to provide a barrier to immunizations.
^ Underserved and Underinsured children are eligible through state funded vaccine program if vaccinated at a county public health clinic.

IMMUNIZATION SCREENING QUESTIONNAIRE	
1. Is the person to be vaccinated currently sick or experiencing a high fever?	__yes __no
2. Has the person to be vaccinated had a serious reaction to a vaccine in the past?	__yes __no
3. Does the person to be vaccinated have any allergies that produce a severe (anaphylactic) reaction?	__yes __no
4. Has the person to be vaccinated had a seizure or other neurological problem?	__yes __no
5. Does the person to be vaccinated have any medical problems that make it hard for him/her to fight infection?	__yes __no
6. Is the person taking cortisone, prednisone, other steroids, or anti-cancer drugs, or had x-ray treatments?	__yes __no
7. Has the person to be vaccinated received blood, plasma, or immune globulin in the past twelve months?	__yes __no
8. Is the person to be vaccinated pregnant or thinking of becoming pregnant within the next three months?	__yes __no

NAME_____ AGE_____ DOB_____

PROVIDER INFORMATION					
Vaccine Provider:			Clinic Site:		
Street Address:	State:	Zip Code:	Street Address:	State:	Zip Code:

(Circle the appropriate vaccine, dose, extremity, site, route, and enter the manufacturer, lot #, and expiration date.)

FOR CLINICAL USE ONLY

VACCINE	DOSE	EXT	SITE	ROUTE	VIS DATE	MANUFACTURER LOT #	EXP DATE
DTaP DT Td	1 2 3 4 5 B	RT LT	Deltoid Vastus Lat	IM			
DTaP/Hib	4	RT LT	Deltoid Vastus Lat	IM			
DTaP/HepB/EIPV	1 2 3	RT LT	Deltoid Vastus Lat	IM			
Hib	1 2 3 4	RT LT	Deltoid Vastus Lat	IM			
Hib/Hep B	1 2 3	RT LT	Deltoid Vastus Lat	IM			
Hep B	1 2 3	RT LT	Deltoid Vastus Lat	IM			
HBIG	1	RT LT	Deltoid Vastus Lat	IM			
EIPV	1 2 3 4	RT LT	Upper Arm Thigh	SQ			
PCV7	1 2 3 4	RT LT	Deltoid Vastus Lat	IM			
MMR	1 2	RT LT	Upper Arm Thigh	SQ			
Varicella	1 2	RT LT	Upper Arm Thigh	SQ			
Hep A	1 2 3	RT LT	Deltoid Vastus Lat	IM			
Influenza	1 2	RT LT	Deltoid Vastus Lat	IM			
PPV23	1 2	RT LT	Deltoid Vastus Lat	IM			

_____ _____

Signature and Title of Vaccine Administrator Date