Long Island Select Healthcare

CONSENT FOR IMMUNIZATION

Patient Name _____ Date of Birth _____

I have been offered a copy of the Vaccine Information Statement(s) (VIS) checked below. I have read, had explained to me, and understand the information in the VIS(s). I ask that the vaccine(s) checked below be given to me or to the person named above for whom I am authorized to make this request. (One consent form per vaccine). I give consent to allow this information to be sent to the state registry for reporting.

Tetanus Td ☐ Hepatitis B ☐ Influenza ☐ Pneumococcal ☐

Varicella ☐ Varicella booster ☐ MMR booster ☐ Other _____

_____ _____

Signature of Patient or Parent/Guardian Date

IMMUNIZATION SCREENING QUESTIONNAIRE	(Please circle YES or NO)
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. Does the person to be vaccinated have any medical problems that make it hard for him/her to fight infection?	**YES NO**
5. Does the person to be vaccinated have close, regular contact with someone with a weakened immune system?	**YES NO**
a) Is the person taking cortisone, prednisone, other steroids, or anti-cancer drugs, or had cancer treatments?	**YES NO**
6. Hs the person to be vaccinated received blood, plasma, or immunoglobulin in the past 12 months?	**YES NO**
7. Is the person to be vaccinated pregnant or thinking of becoming pregnant within the next 3 months?	**YES NO**

_____ _____

Questionnaire Completed by Date

FOR CLINICAL USE ONLY

Vaccine	Dose	Ext	Site	Route	VIS Date	Manufacturer Lot#	Exp Date
Tetanus (Td)	1	RT LT	Deltoid Vastus Lat				
HepB/booster	1 2 3/ 1	RT LT	Deltoid Vastus Lat				
Influenza	1	RT LT	Deltoid Vastus Lat				
MMR booster	1	RT LT	Upper Arm Thigh				
Pneumococcal	1	RT LT	Deltoid Vastus Lat				
Varicella/booster	1 2	RT LT	Upper Arm Thigh				
Other (specify)							

Vaccine Administered by _____ Date _____