THAYER COUNTY HEALTH SERVICES VACCINE ADMINISTRATION RECORD

I have been given a copy and have read or have had explained to me the information in the Vaccine Information Statement (s) for the disease(s) and vaccines(s) circled below. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) requested and ask that the vaccine(s) circled below be given to me or the person named below for whom I am authorized to make this request. I accept responsibility for seeking medical attention for any adverse reactions that may arise as a result of receiving the vaccine(s).

Vaccine Date:	
Name:	
Date of Birth:	
Signature:	
(Self or Guardian)	

PRE- VACCINATION SCREENING QUESTIONS:

1. Are you sick today?	yes	no	don't know
2. Do you have allergies to medications, food, a vaccine component, or latex?	yes	no	don't know
3. Have you ever had a serious reaction after receiving a vaccination?	yes	no	don't know
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?	yes	no	don't know
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	yes	no	don't know
6. In the past 3 months, have you taken medications that weaken your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?	yes	no	don't know
7. Have you had a seizure or a brain or other nervous system problem?	yes	no	don't know
8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	yes	no	don't know
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	yes	no	don't know
10. Have you received any vaccinations in the past 4 weeks?	yes	no	don't know

VACCINE ADMINISTRATION RECORD FOR CLINIC USE ONLY

VACCINE and VACCINE INFORMATION STATEMENTS USED:				**Current VIS dates**
Act Hib (2/4/2014)	Rotavirus (08/26/13)	Hep B (2/02/2012)		PPV23(10-6-2009)
Dtap (5-17-07)	MMR (4-20-12)	Tdap (05/09/13)		Influenza (07/26/13)
Hep A (10-25-11)	PCV-13(02/27/13)	Meningococcal (10-14-11)		HPV (5/17/13)
Varicella(3-13-08)	IPV (11-08-11)	Td (2/4/14)		Zostavax10/6/2009

Vaccine manufacturer used for the following vaccines:	
Sanofi Pasteur: ActHib, Adacel, MCV4, Pentacel, IPOL	Merk: MMR, Recomivax Ped, Rotatiq, Varivax, HPV
GSK: Havrix 2dose, Pediarix, Kinrix, Boostrix, Infarix	Pfizer/Wyeth: PCV13

1.) Vaccine	Date Received:	Vaccine Manufacturer/Lot# :
Vaccine Exp. Date:	Injection Site: Rt Deltoid SQ / Lt Deltoid SQ--Rt Deltoid IM / Lt Deltoid IM	
Nurse Signature:		
2.) Vaccine	Date Received:	Vaccine Manufacturer/Lot# :
Vaccine Exp. Date:	Injection Site: Rt Deltoid SQ / Lt Deltoid SQ--Rt Deltoid IM / Lt Deltoid IM	
Nurse Signature:		
3.) Vaccine	Date Received:	Vaccine Manufacturer/Lot# :
Vaccine Exp. Date:	Injection Site: Rt Deltoid SQ / Lt Deltoid SQ--Rt Deltoid IM / Lt Deltoid IM	
Nurse Signature:		