Haywood County Health Department

____Insured _____ NC Health Choice
____Not Insured _____American Indian
____Underinsured _____Alaskan Native
____Medicaid

Last Name_____ First Name_____ Middle _____ Maiden _____

Date of Birth_____ Social Security Number_____-_____-____

Phone Number_____ Race_____ Male_____Female_____

Street Address_____City_____Zip_____
(NO PO BOX)

IMMUNIZATION CONSENT

Please answer the following questions about you or the person who is to receive the shot(s).

1. Are you sick today? Yes No Don't Know

2. Do you have allergies to medications, food, or any vaccine? 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 cancer, leukemia, AIDS, or any other immune system problem? Yes No Don't Know

5. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had x-ray treatments? Yes No Don't Know

6. During the past 3 months, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin? Yes No Don't Know

7. Have you received any vaccinations in the past 4 weeks? Yes No Don't Know

8. FOR CHILDREN: Has the child had a seizure or a brain problem? 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

I have read, or have had explained to me, the information contained in the Vaccine Information Statement(s) regarding the vaccines(s) to be administered today. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the specific vaccine(s) and I ask that the vaccine(s) be given to me or the person for whom I am authorized to make this request. I also authorize the Haywood County Health Department to release my immunization information or the immunization record of the person for whom I am authorized to make this request to appropriate school/child care center personnel or other health care provider(s) as needed.

PLEASE PRINT NAME

_____/_____ _____
Signature of person to be vaccinated or person authorized to make request Date

_____ _____
RN Signature Date

LOT NUMBER AND SITE OF INJECTION

Menactra/Menveo _____ RT Deltoid_____LT Deltoid_____

Tdap_____RT Deltoid_____LT Deltoid_____