



PRINT

Patient

First Name

Last Name

Birth Date:

Middle Initial:

Sex:

Age:

Family and Address Information:

Guardian First Name:

Guardian Last Name:

Address:

P.O. Box:

Zip code:

City:

State:

Mother Maiden Name:

Phone #

Office Use:

SIIS Patient ID:

GNOIN Chart #

Other Info

Race: Asian or Pacific Islander

American Indian or Alaskan Native

Black, not of Hispanic origin

White, not of Hispanic origin

Hispanic

Other _____

Language: English

Spanish

French

Vietnamese

Other _____

Physician: _____

VACCINE ADMINISTRATION RECORD AND REGISTRY AUTHORIZATION

I agree to allow information about all vaccinations given to me or to the person for whom I am authorized to consent to be released to other medical care providers, schools, child care, or head start centers to avoid the administration of unnecessary vaccinations and to determine immunization status. I understand that this will remain in effect until canceled by me in writing. I hereby consent to the administration of the indicated immunizations. I acknowledge I have received and reviewed the CDC information on the risks and benefits of immunizations and that I have been allowed to ask questions and have had my questions satisfactorily answered.

Signature of Parent/Guardian or adult vaccine recipient _____

Date: _____

SEE BACK

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|--|-----|----|------------|
| | Yes | No | Don't Know |
|--|-----|----|------------|
1. Does the child have any health problems, now or in the past?
If yes, please list: _____
 2. Does the child have allergies to vaccines, medications, Thimerosal, Gentamicin, gelatin, baker's yeast, eggs or egg products?
If yes, please list: _____
 3. Has the child had a serious reaction to a vaccine in the past?
If yes, please list: _____
 4. Does the child have cancer, leukemia, AIDS, or any other immune system disorder? If yes, please list: _____
 5. Has the child taken cortisone, prednisone or other steroids; anticancer drugs, or had radiation treatment in the past 3 months?
If yes, please list: _____
 6. Has the child received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin in the past year?
If yes, please list: _____
 7. Is the child/teen pregnant or at risk of becoming pregnant in the next month?
If yes, please list: _____
 8. Has the child had chickenpox disease?
 9. Has the child received the chickenpox vaccine?
 10. Has the child received any vaccinations in the past 4 weeks?
If yes, please list: _____
 11. Does your child have a prior history of Guillain-Barre Syndrome?
If yes, please list: _____
 12. Has your child ever received the flu vaccine before?
If yes, please list: _____
 13. List any current medications: _____

FOR CLINIC USE ONLY

I certify that the Vaccine Information Statement(s) for vaccine(s) administered below were presented to the person or parent/guardian named above, at the clinic and on the date shown here.

Signature and title of the

Clinic: _____ **Date:** _____ **Vaccine Administrator** _____

DTaP / Td / TDaP	IPV	MMR	HIB	MMRV
Site of Injection: LA RA LT RT	Site of Injection: LA RA LT RT	Site of Injection: LA RA LT RT	Site of Injection: LA RA LT RT	Site of Injection: LA RA LT RT
Dose 1 2 3 4 5	Dose 1 2 3 4 5	Dose 1 2 3 4 5	Dose 1 2 3 4 5	Dose 1 2 3 4 5

HBV	HAV	VARICELLA	FLU	RV
Site of Injection: LA RA LT RT	Site of Injection: LA RA LT RT	Site of Injection: LA RA LT RT	Site of Injection: LA RA LT RT	Oral Dose
Dose 1 2 3 4 5	Dose 1 2 3 4 5	Dose 1 2 3 4 5	Dose 1 2 3 4 5	1 2 3 4 5

HPV	PCV-7	PEDIARIX	MCV4	OTHER
Site of Injection: LA RA LT RT	Site of Injection: LA RA LT RT	Site of Injection: LA RA LT RT	Site of Injection: LA RA LT RT	Site of Injection: LA RA LT RT
Dose 1 2 3 4 5	Dose 1 2 3 4 5	Dose 1 2 3 4 5	Dose 1 2 3 4 5	Dose 1 2 3 4 5