Franciscan WORKINGWell

Immunizations Consent

4527 E 82nd Street
Indianapolis, IN 46250
317-528-6374

PLEASE PRINT AND FILL OUT COMPLETELY

Name: _____ Birthdate: _____ Age: _____ Gender: M or F

Address: _____ City: _____ State: _____ Zip: _____

Home Phone/ Cell Phone: _____ Race: _____

Insurance Company: _____Policy#_____

Policy Holders name: _____D.O.B._____Relationship:_____

Medical History: **The following will help us determine your eligibility for requested immunizations. Please answer to the best of your ability.**

1. Are you Pregnant or planning a pregnancy in the next 4 weeks?	**YES**	**NO**
2. Are you currently ill with a fever, vomiting or diarrhea?	**YES**	**NO**
3. Are 19 years or older with: Tuberculosis, Multiple Sclerosis, Thrombocytopenia, functional Or anatomic asplenia, CSF leak Cochlear implant, Leukemia, Lymphoma, HIV/AIDS, Open Heart or Organ Transplant, an immunocompromising condition, or Receiving infusions, injections, antivirals, Antibiotics or radiation?	**YES**	**NO**
4. Do you have a history of thymus disease (including myasthenia gravis)?(YF only)	**YES**	**NO**
5. Have you received blood/plasma/immune globulin or had a vaccine in the last 4 weeks?	**YES**	**NO**
6. Have you ever fainted, became dizzy or had a serious reaction after an immunization?	**YES**	**NO**
7. Have you ever had a seizure disorder for which you require medication, a brain Disorder, Guillain-Barre Syndrome or any other nervous system disorder?	**YES**	**NO**
8. Are you allergic to any medications, foods or vaccines and their components? (such as eggs, bovine protein,toxoids,sorbitol,neomycin,phenol,yeast,thimerosal,latex,protamine sulfate or formaldehyde)	**YES**	**NO**

ACKNOWLEDGEMENT/ RELEASE OF LIABILITY AND CONSENT TO RECEIVE IMMUNIZATION(S):

- WRITTEN MD APPROVAL IS REQUIRED FOR CHILDREN UNDER THE AGE OF 8 YEARS FOR POLIO, RABIES AND MMR. YELLOW FEVER REQUIRES WRITTEN MD APPROVAL FOR PERSONS WITH MULTIPLE SCLEROSIS**,** CHILDREN UNDER 9 YEARS OR ADULTS OVER 59 YEARS. HEPATITIS A, B OR COMBO VACCINES ALSO REQUIRE MD APPROVAL FOR PERSONS WITH MS.
- **I** HAVE READ OR HAVE BEEN OFFERED A COPY OF THE CURRENT VACCINE INFORMATION SHEET PRIOR TO MY VACCINATION. I HAVE HAD A CHANCE TO ASK QUESTIONS AND I UNDERSTAND ALL THE RISKS AND BENEFITS INVOLOVED.
- I AGREE TO STAY IN THE AREA FOR 15 MINUTES AFTER RECEIVING MY VACCINATION TO ENSURE THAT NO IMMEDIATE REACTIONS OCCUR. I UNDERSTAND THAT IF I EXPERIENCE ANY SIDE EFFECTS IT WILL BE MY RESPONSIBILITY TO GOLLOW UP WITH MY PHYSICAN AT MY EXPENSE. LOCAL REACTIONS MAY INCLUDE BURNING, SWELLING, WHEAL, TENDERNESS OR BLISTERING AT SITE. GENERAL REACTIONS MAY INCLUDE FEVER, FATIGUE, DIARRHEA, NAUSEA, VOMITING, HEADACHE, ARTHRITIS, MALAISE AND MYALIA. SEVERE REACTIONS INCLUDE ANAPHYLAXIS, ENCEPHALITIS, GUILLAIN-BARRE AND FEBRILE CONVULSIONS.
- I UNDERSTAND THE VACCINE IS BEING PROVIDED BY FRANCISCAN WORKINGWELL. I EXPRESSLY RELEASE FROM ANY LIABILITY THE ABOVE NAMED ORGANIZATION AND INDIVIDUAL GIVING THE VACCINE(S). I, FOR MYSELF, MY HEIRS, EXECUTORS AND ASSIGNS HEREBY AGREE TO RELEASE THE SITE PROVIDER AND ITS EMPLOYEES FROM ANY AND ALL CLAIMS ARISING OUT OF, IN CONNECTION WITH OR IN ANY WAY RELATED TO MY RECEIPT OF THIS VACCINE(S) IN THEIR FACILITIES.
- I HAVE READ THIS CONSENT AND I AUTHORIZE FRANCISCAN WORKINWELL TO GIVE THE ABOVED NAMED VACCINE TO ME OR THE PERSON NAMED FOR WHICH I AM AUTHORIZED TO SIGN.
- I ACKNOWLEDGE THAT SOME VACCINES REQUIRE MULTIPLE DOSES AND/OR UP TO 2 WEEKS TO RECEIVE FULL PROTECTION.

X_____ _____

Patient Signature (parent or guardian if patient is under 18) Offered/Read HIPAA Privacy Practices Date

Additional lines are for second and third dose consent; please let us know if any information above has changed.

X_____ _____

Patient Signature (parent or guardian if patient is under 18) Offered/Read HIPAA Privacy Practices Date

X_____ _____

Patient Signature (parent or guardian if patient is under 18) Offered/Read HIPAA Privacy Practices Date

VACCINE	DOSAGE	SITE	LOT #	EXP DATE	VIS	SIGNATURE/DATE
DTAP (Infanrix) should get 5 doses Dosage: 2 months,4 months, 6months,15-18 months, 4-6 years	0.5 CC IM					
CHICKEN POX (VARICELLA) **LIVE** first dose at 12 through 15 months old second dose at 4 through 6 years	0.5 CC SUBQ					
FLU SHOT OR FLUMIST	0.5 CC IM					
HEPATITIS A (Havrix) 12 months & up Dosage: now and 6-12 months	0.5 CC IM					1
						2
HEPATITIS B (Engerix B) Dosage: now, 1 month, 6 month	0.5 CC IM					1
						2
						3
PCV13 (PREVNAR13**)** Dosage 2,4,6,12-15 months 24 months and up to 6th birthday never had vaccine they should only receive 1 dose	0.5 CC IM					1
						2
						3
						4
HPV9 (Gardasil9) can start at age 9 Dosage: now, 2 months, 6 months	0.5 CC IM					1
						2
						3
Meningococcal Group B **(**BEXSERO) Dosage: month apart	0.5 CC IM					1
						2
MCV4 (Menactra) Dosage: Two doses: the first dose at 11 or 12 years of age, with a booster dose at age 16.	0.5CC IM					1
						2
MMR **First Dose**: 12-15 months of age **Second Dose**: 4-6 years of age (may be given earlier, if at least 28 days after the 1st dose	0.5 CC SUBQ					1
						2
MMR-V (ProQuad) **Do not give if**: history of anaphylactic reaction to neomycin or hypersensitivity to gelatin	0.5 CC SUBQ					1
						2
Tdap (Boostrix, Adacel) 10 years and older	0.5 CC IM					