

VACCINE INFORMATION AND CONSENT FORM

Name:										
	First Mi		Middle	le I		La	st			
Address:										
	Street				City		Sta	te	Z	ip
Telephone: ()										
Date of Birth:		Age: (Gender:	Primary 1	Langua	1		nicity:	(chec	ck only 1)
			□Male	□ English				lot Hispanic		
							☐ Hispanic ☐ Unknown			
Race: (check only 1) Asian/Polynesian Black Multiracial White Native Am/Alaskan Unknown										
Please answer the health questions below: Yes No Don't										
Please answer the health questions below:								168	110	Know
1. Are you sick too	day?									
2. Are you allergion	to anything includ	ing any food, an	y vaccine, a	ny vaccine c	omponer	nt, or latex	?			
3. Have you ever l	nad a serious reaction	on after receiving	g a vaccinati	on?						
·	ved any vaccination									
	you live with or tal			•	em?					
6. Do you have an	y history of seizure	s or neurological	l conditions?	?						
7. Do you, anyone	you live with or tal	ke care of take st	teroids, anti-	-cancer drugs	s or x-ray	treatmen	ts?			
8. Is it possible that	at you are or may be	ecome pregnant i	in the next for	our weeks?						
9. In the last year have you received blood or plasma or been given immune globulin?										
3 . 111 till 1000 j cm	J	nood of plasma o	or been give	n immune gi	obulin?					
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	Ins	surance/Paym	ent Inforr	nation (ch	eck onl					
☐ Self-pay – Ar	Ins	surance/Paym	ent Inforr	nation (ch - Company	eck onl Name:					
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