

Routine Childhood Vaccine Consent, 0-18 years

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The vaccines we recommend for you or your child today are checked on this consent form. Please answer the questions with each recommended vaccine. If you answer "yes" to any of these questions or you don't know the answer, please don't sign this form before you talk to your doctor or nurse. Please read the Vaccine Information Statements (VIS) we gave you for the vaccines marked.

Influenza Vaccine Card / Sticker

Name _____

Member I.D. Number _____

Date of Birth _____

Insurance status (check one) <input type="checkbox"/> Private insurance (ex. Kaiser Permanente) <input type="checkbox"/> Uninsured (no health insurance) <input type="checkbox"/> Underinsured (catastrophic insurance only) <input type="checkbox"/> Medicaid (ex. Molina, DSHS)	American Indian/Alaskan Native for Vaccine for Children Program (check one) <input type="checkbox"/> Yes <input type="checkbox"/> No
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- | | | Yes | No |
|---|--------------------------|--------------------------|--------------------------|
| • Has the person getting any of the vaccines marked on this page had a serious (life-threatening) allergic reaction to a previous dose of the vaccine(s) or vaccine components such as latex? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Is the person receiving these vaccines sick now, or have they been sick with a fever of 101 or greater? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Has the person getting any of the vaccines marked on this page received another live vaccine in the last 4 weeks, such as MMR (Measles, Mumps, and Rubella), Shingles, or Varicella? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Recom- mended	Refused Today			Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	Choose one tetanus-containing vaccine. Lot# DTaP (Diphtheria, Tetanus & Pertussis), less than 7 years old • Has this person ever had a serious reaction to DTaP shots (such as fever greater than 105°, seizures, ongoing crying for 3 hours or more, unusual high-pitched cry, or become pale, limp or less alert)? ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	DT (Diphtheria, Tetanus), less than 7 years old Tdap (Tetanus, Diphtheria & Pertussis), 10 years and older • Is this person pregnant and fewer than 20 weeks along? ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	• Has this person had Guillian Barré Syndrome (GBS)? .. • Does this person have a brain or nervous system disease that is getting worse? ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Td (Tetanus, Diphtheria), 7 years and older • Has this person had Guillian Barré Syndrome (GBS)? .. • Does this person have a brain or nervous system disease that is getting worse? ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Haemophilus Influenza B Lot#	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A Lot#	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B Lot# • Is this person allergic to baker's yeast? ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Human Papillomavirus (HPV) Lot# • Is this person pregnant? .. • Is this person allergic to yeast? ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Meningococcal Conjugate (MCV) Lot# • Has this person had Guillian Barré Syndrome (GBS)? ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Recom- mended	Refused Today		Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	Measles, Mumps, and Rubella (MMR) Lot# _____ • Has this person had a serious allergic reaction to the drug neomycin?..... <input type="checkbox"/> <input type="checkbox"/> • Is this person less able to fight serious infections because of any disease (such as cancer, HIV infection), or treatment or drugs (such as steroids or radiation)? This means having a weakened immune system that makes it harder to fight off infection..... <input type="checkbox"/> <input type="checkbox"/> • Is this person pregnant or likely to become pregnant within the next month? <input type="checkbox"/> <input type="checkbox"/> • Has this person been given a blood transfusion or immune globulin during the past several months? <input type="checkbox"/> <input type="checkbox"/> • Has this person ever had a low platelet count?..... <input type="checkbox"/> <input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	Pneumococcal Conjugate (PCV) Lot# _____ • Has this person had a serious allergic reaction to a vaccine containing diphtheria toxoid (such as DTaP)? . <input type="checkbox"/> <input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	Pneumococcal Polysaccharide (PPV), high-risk 2-18 year olds Lot# _____		
<input type="checkbox"/>	<input type="checkbox"/>	Polio (IPV) Lot# _____ • Does this person have an allergy to the drugs neomycin, streptomycin or polymyxin B?..... <input type="checkbox"/> <input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	Rotavirus Lot# _____ • Does this person have ongoing digestive problems or a history of intussusception? <input type="checkbox"/> <input type="checkbox"/> • Does this person have a weakened immune system for any reason? <input type="checkbox"/> <input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox (Varicella) Lot# _____ • Has this person had a severe allergic reaction to the drug neomycin or to gelatin?..... <input type="checkbox"/> <input type="checkbox"/> • Is this person less able to fight serious infections because of any disease (such as cancer, HIV infection), or treatment or drugs (such as steroids or radiation)? <input type="checkbox"/> <input type="checkbox"/> This means having a weakened immune system that makes it harder to fight off infection. • Is this person pregnant or likely to become pregnant within the next month? <input type="checkbox"/> <input type="checkbox"/> • Has this person been given a blood transfusion or immune globulin during the past several months?.. <input type="checkbox"/> <input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	Inactivated Influenza Vaccine Lot# _____ • Has this person had an allergic reaction to eating eggs? <input type="checkbox"/> <input type="checkbox"/> • Has this person had Guillian Barré Syndrome (GBS)?..... <input type="checkbox"/> <input type="checkbox"/> • Is this person pregnant? <input type="checkbox"/> <input type="checkbox"/>		

I read the Centers for Disease Control and Prevention's Vaccine Information Statements (VIS). I had a chance to discuss the nature, alternatives, benefit, and risks of the vaccine(s) marked above. I've had a chance to ask questions and they were answered to my satisfaction. I consent to the administration of the vaccine(s) marked above.

Signature of person authorized to give consent _____ Date _____

For Staff use only: Administered by (Signature & Title Required) _____ Date _____		Document lot number from box next to each vaccine administered
FLU (INFLUENZA) VACCINE <input type="checkbox"/> FluZONE, (6-35 months), Quad *SYRINGE* <input type="checkbox"/> FluZONE, (3-18 yrs), Quad *VIAL* <input type="checkbox"/> FluLAVAL, (6+ months), Quad *SYRINGE* <input type="checkbox"/> FluARIX, (36+ months), Quad *SYRINGE*	MANUFACTURER <input type="checkbox"/> Sanofi-Pasteur <input type="checkbox"/> GSK	