



Vaccine Administration Record & Informed Consent

Patient's Name _____
 Last First Middle

Gender: Male Female Birth Date: _____ Age: _____

Race: Caucasian Black or African American American Indian or Alaskan Native Asian
 Native Hawaiian or other Pacific Islander Unknown or not reported

Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown

Do you have insurance: No Yes If yes, type: _____

If your child has Nevada Medicaid or Nevada Check-Up, would you like a free children's exam? No Yes

VFC Eligibility (Clerk use only):

Not Eligible No Insurance Underinsured Native American or Alaskan Native NV Medicaid NV Check-Up

Did you bring your or your child's immunization record today? No Yes

PLEASE NOTE: It is important for you to have a personal record of your vaccinations. If you don't have a record, ask your health care provider to give one to you. Bring this record with you every time you seek medical care. Make sure your health care provider records all your vaccinations on it. Your child will need this record to enter childcare, kindergarten, college, etc.

The following questions will help us to determine which vaccines may be given today. If a question is not clear, please ask the nurse to explain it:

IS THE PERSON RECEIVING THE VACCINE...	Yes	No	Don't Know
1. Sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Allergic to latex, medications, food or any vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever had a serious reaction after receiving a vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Between the ages of 2 and 4 years and had a healthcare provider tell you that the child had wheezing or asthma in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Been diagnosed with cancer, leukemia, AIDS or any other immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Taking cortisone, prednisone, other steroids, anticancer drugs or x-ray treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Been given a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin during the past year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Had a seizure or a brain problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Received any vaccinations or TB skin tests in the past four (4) weeks or been told to get a TB skin test?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FOR GIRLS/WOMEN 9 years old or older:	Yes	No	Don't Know
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you trying to get pregnant in the next 28 days?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Counseled to avoid pregnancy within the next 28 days: Nurse initial _____ / Client initial _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Informed Consent: I have read or have had explained to me the information contained in the Vaccine Information Statement(s) about the disease(s) and the vaccine(s). I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) indicated on the reverse side be given to me or to the person named above for whom I am authorized to make this request.

Signature of: Client (18 years of age and older) Parent or Guardian

SIGN HERE: _____ **Date:** _____

COMPLETE THE TOP PART ON THE BACK (NAME AND DATE OF BIRTH ONLY) →

Patient's Name _____ Birth Date _____
 Last First Month Day Year

AREA BELOW FOR SNHD STAFF ONLY

Vaccine	Date Given	Dose #	Mfg & Lot #	Site	Route	VIS Date	Administered by (Name/Title)
DTaP				LA RA LT RT	IM	05-17-07	
DT				LA RA LT RT	IM	05-17-07	
Td				LA RA LT RT	IM	04-11-17	
Tdap Adacel Boostrix				LA RA LT RT	IM	02-24-15 02-24-15	
IPV				LA RA LT RT	IM SQ	07-20-16	
HIB Ped Vax Act hib				LA RA LT RT	IM	04-02-15 04-02-15	
MMR				LA RA LT RT	SQ	04-20-12	
Varicella				LA RA LT RT	SQ	03-13-08	
MMRV				LA RA LT RT	SQ	05-21-10	
Hep A				LA RA LT RT	IM	07-20-16	
Hep B				LA RA LT RT	IM	07-20-16	
Hep A/Hep B Twinrix				LA RA LT RT	IM	7-20-16 7-20-16	
Meningococcal Menveo, Menactra Menomune MenB				LA RA LT RT	IM SQ	03-31-16 08-09-16	
PCV13				LA RA LT RT	IM	11-05-15	
DTaP/IPV Kinrix				LA RA LT RT	IM	05-17-07 7-20-16	
DTaP/IPV/HIB Pentacel				LA RA LT RT	IM	05-17-07 7-20-16 04-02-15	
DTaP/IPV/Hep B Pediarix				LA RA LT RT	IM	05-17-07 7-20-16 7-20-16	
Pneumococcal Pneumovax				LA RA LT RT	IM SQ	04-24-15	
Rabies				LA RA LT RT	IM	10-06-09	
Rotavirus Rotateq Rotarix				ORAL	PO	04-15-15 04-15-15	
Flu				LA RA LT RT	IM IN	08-07-15	
Shingles Zostavax				LA RA LT RT	SQ	10-06-09	
HPV Gardasil				LA RA LT RT	IM	12-02-16	
Smallpox				LA RA LT RT	ID		
Typhoid				LA RA	IM	05-29-12	
Yellow Fever				LA RA	SQ	03-30-11	
Newborn Screening							
Multi-Vaccine VIS						11-05-15	

Record # _____ Return Date: _____ VIS Given _____ Clerk _____ Clinician _____

Clinic Location: Main ELV Hend Mesquite _____

Reviewed by: _____ RN / LPN Date: _____

