



Travel Vaccine Administration Record & Informed Consent

Traveling to: _____
(List all destinations to include City and Region if known)

Departure Date: _____ Length of Stay: _____

Patient's Last Name _____ First Name _____ Age: _____

Patient Emergency Contact: (For emergency only such as passing out or needing to be taken to a hospital)
 Name _____ Relationship: _____ Phone Number: _____

Language most comfortable speaking: _____ Do you need an interpreter? Yes No

Hearing impaired or need sign language interpreter services? Yes No

I ACKNOWLEDGE THAT I HAVE RECEIVED THE "NOTICE OF PRIVACY PRACTICE." _____ (INITIAL)

SNHD STAFF ONLY/ VFC Eligibility: Not Eligible Uninsured/Underinsured Native American or Alaskan Native NV Medicaid NV Check-Up

**Complete the following questions to help us 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 vaccines or TB skin tests in the past 4 weeks or been told to get a TB skin test?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FOR FEMALES 9 years old or older:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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"/>
<input type="checkbox"/> Counseled to avoid pregnancy within the next 28 days: Nurse initial _____/Client initial _____			

Informed Consent: *I answered all the questions correctly to the best of my knowledge. 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.*

SIGN HERE: _____ **Date:** _____

Client (18 years of age and older) Parent/Guardian

For Staff Use Only	Nurse Initials	Patient Initials
1. Reviewed key travel information from the CDC website on Traveler's Health.		
2. Reviewed required and/or recommended travel vaccines with patient and: a. Advised patient of required/ recommended travel vaccines; b. Advised patient of required/recommended vaccines that require a patient to follow up with their primary care provider or a travel medicine specialist; c. Advised patient they may choose to receive all recommended travel vaccines from their primary care provider, a travel medicine specialist or SNHD.		
3. Advised patient that SNHD does not provide the following services: prescription for malaria, diarrhea, altitude sickness, Japanese Encephalitis or oral typhoid vaccine, yellow fever exemption letter, blood work to determine immunity, other necessary medical services,. Advised that if any of these are needed, patient needs to contact their primary care provider or travel medicine specialist.		
4. Patient requested the following vaccines: _____		

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	02-12-18	
Varicella				LA RA LT RT	SQ	02-12-18	
MMRV				LA RA LT RT	SQ	02-12-18	
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	07-20-16 07-20-16	
Meningococcal Menveo, Menactra MenB				LA RA LT RT LA RA LT RT	IM IM	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 07-20-16	
DTaP-IPV/HIB Pentacel				LA RA LT RT	IM	05-17-07 7-20-16 04-02-15	
DTaP-IPV-Hep B Pediatrix				LA RA LT RT	IM	05-17-07 7-20-16 07-20-16	
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	02-23-18	
Flu				LA RA LT RT	IM IN	08-07-15	
Shingles				LA RA LT RT	IM	2-12-18	
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 Employee Health Other _____

Reviewed by: _____ RN / LPN Date: _____