



Adolescent Vaccine Administration Record

TO BE COMPLETED IN BLUE OR BLACK INK ONLY

Child's Name _____ Phone Number (____) _____

Last _____ **First** _____ **M.I.** _____
 Male Female Birth date _____ Age _____
 _____ **Month** _____ **Day** _____ **Year** _____

Address _____

Culinary _____ **Other Insurance** _____ **Cash / Check #** _____ **Zip Code** _____
 _____ **Street** _____ **City** _____ **State** _____ *(Made out to SNHD)*
 _____ **Primary Cardholder ID #** _____

Medicaid **Nevada Check-up #** _____ Type: BCBS HPNH
 Select one: Native American or Alaskan Native Insurance **does not** pay for vaccines
 No insurance Insurance **does** pay for vaccines

Do you have a medical doctor? **Yes** Name of provider: _____ **No**

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"/>
11. For girls 9 years and older: When was your last menstrual period? _____			

Disclaimer

I am giving permission for my child to have the **State of Nevada required** Tdap vaccine at this time
 If indicated, my child may also receive the following vaccines Chickenpox Meningococcal Hepatitis A
 I will take my child to my private provider
 My child had the Tdap vaccine on this date _____. *(Must attach a copy of shot records.)*

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 is given to me or to the person named above for whom I am authorized to make this request.

Signature of parent or guardian: _____ Date: _____

Send completed paperwork and payment with your child on the day of the clinic. Forms will be given to health district staff.

AREA BELOW FOR SNHD STAFF ONLY

Vaccine	Date Given	Dose #	Mfg & Lot #	Site*	Route **	VIS Date	Administered by (Name/Title)
Tdap				LA RA LT RT	IM	11-18-08	
Hep A				LA RA LT RT	IM	3-21-06	
Meningococcal				LA RA LT RT	IM	1-28-08	
Varicella				LA RA LT RT	SQ	3-13-08	

*Site: LA (Left Arm), RA (Right Arm), LT (Left Thigh), RT (Right Thigh) **Route: IM (Intramuscular), SQ (*Subcutaneous)

Web IZ Record # _____ VIS Given _____ School Location _____
 _____ Clerk

Reviewed by: _____ RN / LPN Date: _____