

Prefix Last name Middle name First Name DOB

Listed procedure, immunization (s), and/or medication(s)

Have you ever had the immunization(s) before? Yes No If so, when? _____

Are you currently receiving chemotherapy, radiation therapy, steroids, or immunosuppressive therapy? Yes No

Do you have any chronic illnesses that weaken the immune system, such as cancer or HIV/AIDS Yes No

Are you pregnant? Yes No

Are you currently nursing? Yes No

Are you a member of a long term care facility? Yes No

Are you allergic to eggs, neomycin, streptomycin or polymyxin B, baker's yeast, or a vaccine preservatives? Yes No

Do you have any known sensitivities to any components of the vaccine? Yes No

Have you ever had an adverse reaction to a vaccine/immunization? Yes No

Please list the adverse reaction _____

Do you have a history of Gullain-Barre syndrome? Yes No

Do you have a history of sensitivity to latex, such as with latex gloves? Yes No

Do you currently have a fever or respiratory illness or any other type of infection? Yes No

Please also review the individual handouts about each immunization that you will receive today.

I have read the adverse reactions associated with the vaccines. Furthermore, I have had an opportunity to ask questions about this immunization. I am requesting that the immunization be given to me or the person named below for whom I am the legal guardian.

I certify that I if my insurance company, including Medicare/HMOs/PPOs etc. does not cover this procedure or immunization, that I will be responsible for the full cost of the procedure/injection/immunization etc. Also if Medicare or an Insurance company denies payment for the immunization (s), the listed person or guardian/parent will be responsible for the full costs.

Credit card type: please circle Mastercard, Visa, Discover, or American Express

Name on the card _____

Card Number _____

Expiration Date _____

Billing Zip Code _____

Signature to bill the credit card _____

Signature of Consenting Person Please print name after the signature

Date Signed

Physician Signature or Representative