VACCINE DOCUMENTATION/ CONSENT FORM

I have been offered a copy of the Vaccine Information Statement(s) (VIS) checked below. I have read, had explained to me, and understand the information in the VIS(s). I ask that the vaccine(s) checked below be given to me or to the person named below for whom I am authorized to make this request. I consent to inclusion of this immunization data in the Nevada Immunization Registry for myself or on behalf of the person named below. Tdap Influenza

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Signature of Patient or Parent/Guardian Date

PATIENT INFORMATION				
Patient's Last Name:	**Patient's First Name:**	**Phone Number:**	**Age:**	**Birthdate:**
Street Address:	**City:**	**County:**	**State:**	**Zip Code:**

Ethnicity: Hispanic or Latino
___Yes ___No

Gender:
___ Male ___ Female

Race: (Select one or more.)
___ AS- Asian Pacific Islander/ Other
___ BL-Black or African American
___CA- Caucasian/Mexican/Puerto Rican
___CH- Chinese
___ FI- Filipino
___HA- Hawaiian
___ IN- Native American/Alaska Native
___ JA- Japanese
___NW- Other Non-White
___ UN- Unknown

IMMUNIZATION SCREENING QUESTIONAIRE

Is the person being vaccinated currently sick or experiencing a high fever? YES NO

Has the person to be vaccinated had a serious reaction to a vaccine in the past? YES NO

Does the person to be vaccinated have any allergies that produce a severe (anaphylactic) reaction? YES NO

Has the person to be vaccinated had a seizure or other neurological problem? YES NO

Does the person to be vaccinated have any medical problems that make it hard

for him/her to fight infection? YES NO

Does the person to be vaccinated have close, regular contact with someone with a

weakened immune system? YES NO

Is the person taking cortisone, prednisone, other steroids, or anti-cancer drugs, or had x-ray treatments? YES NO

Has the person to be vaccinated received blood, plasma, or immune globulin in the past twelve months? YES NO

Is the person to be vaccinated pregnant or thinking of becoming pregnant within the next three months? YES NO

VACCINE	DOSE	EXT	SITE	ROUTE	VIS DATE	MANUFACTURER LOT #	EXP DATE
DTap	0.5mL	RT LT	Deltoid Vastus Lat	IM	01/24/2012	ADACEL U4383AA	11/24/2014
Influenza	0.5mL	RT LT	Upper Arm Deltoid Vastus Lat	IM	2015-2016	NOVARTIS 1410801	05/31/2016
Td	0.5mL	RT LT	Deltoid Vastus Lat	IM		DECAVAC U3870DA	02/15/2013

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SIGNATURE AND TITLE OF VACCINE ADMINISTRATOR DATE