MEDICAL CENTER PHARMACY

VACCINE DOCUMENTATION/CONSENT FORM

I have been offered a copy of the Vaccine Information Statement(s) (VIS) checked below. I have read or 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 Washington State Immunization Registry for myself or on behalf of the person named below.

☐ COVID Dose # ☐ DTaP Dose # ☐ Flu Dose # ☐ Hep B Dose # ☐ MMR Dose # ☐ Polio Dose # ☐ Tdap Dose # ☐ Varicella Dose # **IIS Reviewer Initial _____**

_____ _____

Signature of Patient or Parent/Guardian Date

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

PATIENT ELIGIBILITY IF UNDER 19 YEARS OLD					
☐ Native Am/Alaska Native	☐ No health insurance	☐ Underinsured*	☐ Medicaid	☐ CHIP**	☐ Private Insurance

*Underinsured: Has insurance that does not cover immunizations.
**CHIP: Enrolled in the Children's Health Insurance Program (CHIP)

SCREENING QUESTIONS		
1. Is the patient to be vaccinated currently sick or experiencing a high fever?	☐yes	☐no
2. Does the patient have allergies to medications, food, a vaccine component, or latex?	☐yes	☐no
3. Has the patient had a serious reaction to a vaccine in the past?	☐yes	☐no
4. Has the patient 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?	☐yes	☐no
5. Has the patient, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	☐yes	☐no
6. Does the patient have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐yes	☐no
7. In the past 3 months, has the patient taken medications that weaken their immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments?	☐yes	☐no
8. In the past year, has the patient received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐yes	☐no
9. Is the patient pregnant or is there a chance she could become pregnant during the next month?	☐yes	☐no
10. Has the patient received vaccinations in the past 4 weeks?	☐yes	☐no

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FOR CLINICAL USE ONLY

VACCINATION INFORMATION
Vaccinator Name, Credentials (*e.g. Sue Jones, RN*):
Clinic site: ☐

Vaccine	Manufacturer	Exp Date	Lot #	Deltoid Injection Site	Route	VIS PUB DATE	Date VIS Given
Hep A (Havrix)	GSK	4/28/2023	4CY9H	Right Left	IM	10/15/2021	
Hep B (Engerix B)	GSK	4/7/2024	333M4	Right Left	IM	10/15/2021	
Tdap ≥7 years	GSK	11/23/2023	N254C	Right Left	IM	8/6/2021	
IPV (Polio)	Sanofi Pasteur	2/15/2024	V1A12M	Right Left	SC	8/6/2021	
MMR	Merck	3/23/2023	UO13035	Right Left	SC	8/6/2021	
VAR (Varivax)	Merck	12/15/23 or 12/16/23	UO39722 or UO39949	Right Left	SC	8/6/2021	
MCV (MenQuadfi)	Sanofi Pasteur	3/11/2024	U7249AA	Right Left	IM	8/6/2021	
MenB (Trumenba)	Pfizer	6/30/2024	EW6499	Right Left	IM	8/6/2021	
HPV (Gardasil 9)	Merck	8/20/2023	1775808	Right Left	IM	8/6/2021	
COVID-19				Right Left	IM		
Flu				Right Left	IM		
Pharmacist signature			**Date**				