Girls to Women HEALTH AND WELLNESS

Immunization Signature Sheet

Young Men's HEALTH AND WELLNESS

Patient Name: _____DOB: ___/___/___ Today's Date: ___/___/___

All Vaccines:

□ Yes □ No Is the patient sick today?

□ Yes □ No Has the patient had a serious reaction to a vaccine in the past?

Fluzone Vaccine Only:

□ Yes □ No Has the patient ever had a serious allergic reaction to eggs, formaldehyde, or gelatin?

□ Yes □ No Does the patient have a history of Guillain-Barre Syndrome?

Varivax Vaccine Only:

□ Yes □ No Has the patient ever had a serious allergic reaction to gelatin or neomycin ?

□ Yes □ No Has the patient recently been treated with oral steroids for 2 weeks or longer?

□ Yes □ No Does the patient have cancer or HIV/AIDS?

□ Yes □ No Has the patient received a recent blood transfusion?

**"I have read the Vaccine Information Sheet, or have had explained to me the information about the diseases and the vaccines listed below. I believe I understand the benefits and risks of the vaccines cited, and ask that the vaccine(s) listed below be given to me or to the person named below for whom I am authorized to make this request."

□ Parent/Guardian OR □ Patient: _____ **

	MD Approval	Manuf.	Vaccine Lot Number	Exp Date	SITE Given	Vaccine Admin Init*	**Signature of Parent / Guardian / Patient	Admin Route
Adacel (Tdap)		Sanofi			LD RD		X	IM
Gardasil (HPV)		Merck			LD RD		X	IM
Hepatitis A		Merck			LD RD		X	IM
Menactra (MCV4)		Sanofi			LD RD		X	IM
Bexsero (Meningitis B)		GSK			LD RD		X	IM
PPD/TB		Sanofi			LF RF		X	ID
Fluzone		Sanofi			LD RD		X	IM
Varivax (Varicella)		Merck			LT RT		X	SC

**Signature or "Verbal OK" or "In Pt Record"

If YES to any of the above questions, MD Approval Required.

*Vaccine Administrator Signature: