ADULT Vaccine Documentation/Consent Form

Last Name____________________ **First Name**_________________ **Birth Date** ___ /___ /_____

Street Address___________________________ **City:**_____________ **State**_____ **Zip** ________

Mailing Address (if different from above) ____

Preferred Phone __________________________ **Other phone** ___________________________

Race: Select one or more

___Asian/Pacific Islander/Other
___Black or African American
___Caucasian/Mexican/Puerto Rican
___Chinese
___Filipino `
___ Other__________________________
___ Hawaiian
___ Native American/Alaska Native
___ Japanese
___ Other Non-White
___ White

Ethnicity: Hispanic or Latino ___Yes ___No **Gender:** ___Male ___Female

Primary Care Provider ___________________________________

Payment type: Insurance Self Pay Bill to business___________________

Screening Questions

1. Are you sick or experiencing a high fever today? Yes No
2. Do you have allergies to medications, food, a vaccine component, or latex? Yes No
3. Have you had a serious reaction to a vaccine in the past? Yes No
4. Have you had a lung, heart, kidney or metabolic disease (diabetes), asthma, blood disorder or on long term aspirin therapy? Yes No
5. Have you, a sibling, or a parent had a seizure; brain or nervous system problems? Yes No
6. Do you have cancer, leukemia, HIV/AIDS, or other immune system problem? Yes No
7. In the past 3 months, have you taken medications that weaken the immune system? (cortisone, prednisone, other steroids, or anticancer drugs, or radiation) Yes No
8. In the past year, have you received a transfusion of blood or blood products or been given immune (gamma) globulin or antiviral drug? Yes No
9. Are you pregnant or could you become pregnant in the next month? Yes No
10. Have you had any vaccinations in the past 4 weeks? Yes No