COMMUNITY VACCINATION

FORM VACCINE Consent

TDAP AND/OR MENINGOCOCCAL ACWY VACCINE CONSENT FORM

MARTINSVILLE HENRY COUNTY COALITION FOR HEALTH AND WELLNESS

Private Insurance

VFC

Information about person to receive vaccine (please print)

Name: _____ **Birth date**: ___/___/_____ **Age**: _____ **Sex**: ☐ Male ☐ Female

Race: ☐Asian ☐Black ☐Native American ☐Pacific Islander ☐White ☐Other **Ethnicity**: ☐Hispanic ☐Non-Hispanic

Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Phone: _____ SS#_____ **Do you have insurance?** ☐ No ☐ Yes

The following questions will help determine if there is any reason you should not receive a vaccine/ immunization injection.

Answering "yes" to any question does not prevent you from being vaccinated. It means additional questions will be asked. If a question is not clear, please ask a healthcare provider to explain.

Has the person to be vaccinated ever had an allergic reaction after a previous dose of any vaccine received in the past?	☐ No ☐Yes
If yes, list which vaccine/vaccines? _____	
Does the person to be vaccinated have an allergy to any medications, food, vaccine, or latex?	☐ No ☐Yes
List all allergies: _____	
Is the person to be vaccinated sick today?	☐ No ☐Yes
Is the person to be vaccinated at least 7 years of age or older?	☐ No ☐Yes
Does the person to be vaccinated have a bleeding disorder or are they taking a blood thinner?	☐ No ☐Yes
Has the person to be vaccinated received an MMR (Measles Mumps Rubella) or Varicella (Chickenpox) vaccine, in the past 14 days?	☐ No ☐Yes
Does the person to be vaccinated have a history of a coma, decreased level of consciousness, or prolong seizures within 7 days after a previous dose of any Pertussis (Whooping Cough) vaccine?	☐ No ☐ Yes
Has the person to be vaccinated ever had Guillain-Barre Syndrome?	☐ No ☐ Yes

I have read, or have had explained to me, the VIS Sheet (Vaccine Information sheet/sheets). I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine/vaccines and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request (parent or guardian).

I HAVE BEEN ADVISED TO WAIT FOR 15-30 MINUTES OF OBSERVATION AFTER RECEIVING MY VACCINE BEFORE LEAVING.

Print PARENT/GUARDIAN NAME, if different from client: _____

Client/ PARENT/GUARDIAN Signature: _____Date: _____

**********FOR CLINIC USE ONLY**********

Clinic site: ***Henry Co. Public School/MHC Coalition*** ***VIS Sheet/Sheets provided:*** *Yes* *No*

Date administered: _____

Manufacturer/Lot#: ***GSK/Boostrix(Tdap) /_____*** ***Site of IM injection:*** *RDT or LDT* ***Dose:*** *0.5ml*

Manufacturer/Lot#: ***GSK/Menveo(Meningitis)/_____*** ***Site of IM injection:*** *RDT or LDT* ***Dose:*** *0.5ml*

Signature and title of vaccine administrator: _____