VACCINE DOCUMENTATION & CONSENT FORM

I am authorized to consent for the patient named below to receive the Vaccine(s) checked below. I request that the Vaccine(s) be given to the patient named below. I have been provided with the current edition of the Vaccine Information Statement(s) or Recipient Caregiver Fact Sheet(s) for the Vaccine(s) checked below and have had an opportunity to review. I understand that Public Health will provide the patient's vaccine record to the Washington State Immunization Information System (which helps medical providers keep vaccine records up-to-date and see vaccines given by other providers).

☐COVID-19 ☐DTaP ☐Influenza ☐Hepatitis A ☐Hepatitis B ☐Hib ☐HPV ☐MMR ☐Meningococcal ACWY

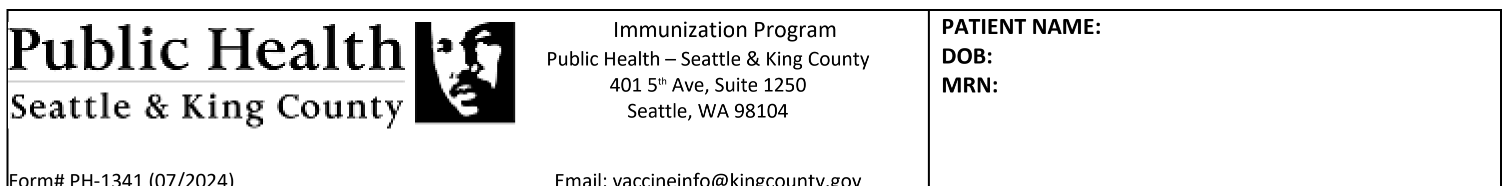
☐Meningococcal B ☐Mpox ☐Pneumococcal ☐Polio ☐Rotavirus ☐RSV ☐Shingles ☐Td ☐Tdap ☐Varicella

Signature of Patient or Authorized Adult	Print Name and Relationship to Patient if signed by person other than patient	Date

<table>
<tr><th colspan="6">PATIENT INFORMATION</th></tr>
<tr><td colspan="3">First Name   Last Name</td><td colspan="2">Age</td><td>Birth Date</td></tr>
<tr><td>Sex Assigned at Birth</td><td colspan="2">Mother's Maiden Name</td><td colspan="3">Authorized Adult's First Name</td></tr>
<tr><td colspan="4">Race (mark all that apply) ☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐Native Hawaiian or Pacific Islander ☐White ☐Other ☐Unknown</td><td colspan="2">Ethnicity (mark all that apply)
☐Hispanic/Latino ☐Non-Hispanic/Latino</td></tr>
<tr><td colspan="2">Street Address</td><td>City</td><td>State</td><td colspan="2">Zip Code</td></tr>
<tr><td colspan="3">Preferred Pronouns (Optional):</td><td colspan="3">Preferred Language (Optional):
☐Interpreter needed</td></tr>
<tr><th colspan="6">CHILDHOOD VACCINE PROGRAM ELIGIBILITY (CHILDREN 18 YEARS AND UNDER)</th></tr>
<tr><td>☐American Indian or Alaska Native</td><td>☐No health insurance</td><td>☐Underinsured*</td><td>☐Medicaid</td><td>☐CHIP**</td><td>☐Private Insurance</td></tr>
<tr><th colspan="6">ADULT VACCINE PROGRAM ELIGIBILITY (ADULTS 19 YEARS AND OVER)</th></tr>
<tr><td colspan="6">☐No health insurance</td></tr>
</table>

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

SCREENING QUESTIONS	Yes	No
1. Are you sick today?	☐	☐
2. Do you have a serious allergy to any medications, food, a vaccine component, or latex? If yes, please list:	☐	☐
3. Have you ever had a serious reaction after receiving a vaccine?	☐	☐
4. Do you have any of the following: health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak? Are you on long-term aspirin therapy?	☐	☐
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problems?	☐	☐
6. Do you have a parent, brother, or sister with an immune system problem?	☐	☐



Immunization Program
Public Health – Seattle & King County
401 5th Ave, Suite 1250
Seattle, WA 98104
Email: vaccineinfo@kingcounty.gov

PATIENT NAME:
DOB:
MRN:

Form# PH-1341 (07/2024)

7. In the past 6 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anti-cancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?	☐	☐
8. Have you had a seizure or a brain or other nervous system problem?	☐	☐
9. Have you ever been diagnosed with a heart condition (myocarditis or pericarditis) or have you had Multisystem Inflammatory Syndrome (MIS-A or MIS-C) after in infection with the virus that causes COVID-19?	☐	☐
10. In the past year, have you received immune (gamma) globulin, blood/blood products, or an antiviral drug?	☐	☐
11. Are you pregnant?	☐	☐
12. Have you received any vaccinations in the past 4 weeks?	☐	☐
13. Have you ever felt dizzy or faint before, during, or after a shot?	☐	☐
14. Are you anxious about getting a shot today?	☐	☐
15. ***For babies eligible for rotavirus vaccine***: Have you ever been told your child has intussusception?	☐	☐
16. ***For children ages 2-4 years eligible for influenza vaccine****:* Has a healthcare provider told you that your child has wheezing or asthma in the past 12 months?	☐	☐
17. ***For patients eligible for influenza vaccine****: Have you ever had Guillain-Barré syndrome?*	☐	☐

FOR OFFICE USE ONLY

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

(Circle the appropriate vaccine, type, site, route, lot #, expiration date and VIS given date.)

VACCINE	TYPE	SITE*	ROUTE*	LOT #	MFR	VIS/Fact Sheet Edition DATE	DATE VIS GIVEN
COVID-19			IM			10/19/23	
DTaP			IM			8/6/21	
Hep A			IM			10/15/21	
Hep B			IM			5/12/23	
Hib			IM			8/6/21	
HPV			IM			8/6/21	
Influenza			IM NAS			8/6/21	
MMR			SC			8/6/21	
MMR-V			SC IM			8/6/21	
Men ACWY			IM			8/6/21	

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PATIENT NAME:
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Men B			IM			8/6/21	
Mpox/Smallpox			SC ID			11/14/22	
Pneumococcal conjugate			IM			5/12/23	
Pneumococcal polysaccharide			IM SC			10/30/19	
Polio (IPV)			IM			8/6/21	
Rotavirus			PO			10/15/21	
RSV			IM			9/5/23	
Shingles (Zoster)			IM			2/4/22	
Td			IM			8/6/21	
Tdap			IM			8/6/21	
Varicella			SC IM			8/6/21	
Other (specify)							
Other (specify)							
Other (specify)							
Other (specify)							

*Record the route by which the vaccine was given as either intramuscular (IM), intradermal (ID), subcutaneous (SC), intranasal (NAS), or oral (PO). Also record the site where it was administered as either RA (right arm), LA (left arm), RT (right thigh), or LT (left thigh).