Memorial Care

Vaccination Authorization Form

Patient name: _____ DOB: _____ Age: _____

The following questions will help us determine which vaccines you or your child may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. Additional questions may be asked. If a question is not clear, please ask your healthcare provider for further explanation.

Flu Vaccine Questions

1.	Is the patient sick (worse than a cold) or had a fever in the last 24 hours greater than 100.8°F?	YES	NO
2.	Has the patient ever had a reaction to the influenza vaccine in the past?	YES	NO
3.	Is the patient allergic to Thimersol or eggs?	YES	NO
4.	Has the patient had Guillain-Barre?	YES	NO

Non-Flu Vaccine Questions

5.	Is the patient sick (worse than a cold) or had a fever in the last 24 hours greater than 100.8?	YES	NO
6.	Is the patient allergic to Neomycin, Thimersol or eggs?	YES	NO
7.	Has the patient had a serious reaction to a shot in the past?	YES	NO
8.	Has the patient or a parent had a seizure? If pediatric, any other nervous system problems?	YES	NO
9.	Does the patient or close contact of the patient have cancer, leukemia, HIV/AIDS, received radiation therapy or have any other immune system problems?	YES	NO
10.	In the past three months, has the patient taken long-term steroids, like cortisone or prednisone?	YES	NO
11.	In the past year, has the patient received a blood, plasma transfusion or immune globulin?	YES	NO
12.	Has the patient received any shots or a TB skin test in the past four weeks?	YES	NO
13.	Is there a chance the patient is or could become pregnant during the next month?	YES	NO

PEDIATRICS			ADOLESCENT/ADULT		
Injection	Site/Initials	Dose	Injection	Site/Initials	Dose
Pediarix (DTaP, IPV, Hep B)		0.5ml	Menveo (Men. A, C, Y, W)		0.5ml
Hiberix (Hib)		0.5ml	Boostrix (Tdap)		0.5ml
Prevnar 13		0.5ml	Gardasil (HPV)		0.5ml
Rotarix (Rotavirus)		1.0ml	Bexsero (Men B)		0.5ml
Havrix (Hep A)		0.5ml	Trumenba (Men B)		0.5ml
Priorix/MMR		0.5ml	Shingrix (Shingles)		0.5ml
Varivax (Varivax)		0.5ml	Tenivac (Td)		0.5ml
Infanrix (DTaP)		0.5ml	Prevnar 20		0.5ml
Kinrix (DTaP, IPV)		0.5ml	Pneumovax (PPSV23)		0.5ml
ProQuad (MMR, Varicella)		0.5ml	Engerix (Hep B) (Adult)		1.0ml
Fluarix/FluLaval (Flu)		0.5ml	Havrix (Hep A) (Adult)		1.0ml
Fluzone High-Dose (65+)		0.7ml			

I have read and/or understand the information on the vaccine information sheet for the immunizations I am to receive. I was able to ask questions which were answered to my satisfaction. I understand the benefits and risks of these immunizations. I agree to remain in the clinic area for 15–30 minutes after receiving a vaccine if indicated by my provider.

Patient/legal guardian: _____ Date: _____

Provider signature: _____ Date: _____

Staff member verifying immunization(s): _____ Date: _____

Staff member verifying immunization(s): _____ Date: _____