

Information about Person to Receive Vaccine (Please Print)

Name: _____
 Last: _____ First: _____ MI: _____

Address: _____ Birthdate: _____ Age: _____

City: _____ State: _____ Zip Code: _____

"I have been given a copy and have read or have had explained to me the information in the Vaccine Information Statement about the vaccine(s) that will be administered. 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(s) and ask that the vaccine(s) be given to me or to the person named above for whom I am authorized to make this request." (Vaccine Information Statements: DTaP - 7/3/06; Td - 6/10/94; Polio - 1/1/2000; HepB - 7/11/2001; MMR - 1/15/03; Hib - 12/16/98; Varicella - 1/10/07; PCV - 9/30/02; Meningococcal - 10/7/05; Tdap- 7/12/06; HepA - 3/21/06; Rotavirus - 4/12/06; HPV - 9/5/06).

Signature of person to receive vaccine or person authorized to make the request (parent or guardian).

X _____ Date: _____

FOR OFFICE/CLINIC USE ONLY

Revised 04/24/07

Clinic/Office Address: LEE COUNTY HEALTH DEPARTMENT • 309 South Galena, Suite 100 • Dixon, IL 61021

Signature of Vaccine Administrator: _____ Title: **RN**

<p>DTaP <input type="checkbox"/> Td <input type="checkbox"/> Tdap <input type="checkbox"/></p> <p align="center">A <input type="checkbox"/> B <input type="checkbox"/></p> <p>Date Administered: _____ Manuf/Lot# _____ EXP: _____ Site: <u>IM</u></p>	<p>MMR <input type="checkbox"/> MMRV <input type="checkbox"/></p> <p>Date Administered: _____ Manuf/Lot# _____ EXP: _____ Site: <u>SQ</u></p>
<p>IPV <input type="checkbox"/></p> <p>Date Administered: _____ Manuf/Lot# _____ EXP: _____ Site: <u>SQ</u></p>	<p>Varicella <input type="checkbox"/></p> <p>Date Administered: _____ Manuf/Lot# _____ EXP: _____ Site: <u>SQ</u></p>
<p>Rotavirus <input type="checkbox"/></p> <p>Date Administered: _____ Manuf/Lot# _____ EXP: _____ Site: <u>ORAL</u></p>	<p>Hib <input type="checkbox"/> Pedvax Hib <input type="checkbox"/></p> <p>Date Administered: _____ Manuf/Lot# _____ EXP: _____ Site: <u>IM</u></p>
<p>PCV <input type="checkbox"/></p> <p>Date Administered: _____ Manuf/Lot# _____ EXP: _____ Site: <u>IM</u></p>	<p>DTaP/Hepatitis B/IPV <input type="checkbox"/></p> <p>Date Administered: _____ Manuf/Lot# _____ EXP: _____ Site: <u>IM</u></p>
<p>Hepatitis B <input type="checkbox"/> Hepatitis A <input type="checkbox"/></p> <p>Date Administered: _____ Manuf/Lot# _____ EXP: _____ Site: <u>IM</u></p>	<p>Meningococcal (MCV4) <input type="checkbox"/></p> <p>Date Administered: _____ Manuf/Lot# _____ EXP: _____ Site: <u>IM</u></p>
<p>HPV <input type="checkbox"/></p> <p>Date Administered: _____ Manuf/Lot# _____ EXP: _____ Site: <u>IM</u></p>	

PLEASE CHECK THE ANSWER TO THE QUESTIONS BELOW AND SIGN YOUR NAME

NAME OF PERSON TO RECEIVE VACCINE: _____ Male Female

- | | | YES | NO |
|-----|--|--------------------------|--------------------------|
| 1) | Does this person have a fever or is this person ill at this time with anything other than a cold? (MMR, Hib, Hep. B, Td, Varicella, DTaP, IPV, PCV, MCV4, Tdap, Hep. A, Rotavirus, HPV) | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) | Has this person had a SERIOUS reaction to immunization such as fever greater than 105°, convulsions, total collapse or shock, a high-pitched cry or screaming episode of 3 hours or more, severe itching rash or anaphylactic allergic reaction? (MMR, Hib, Td, Hep. B, DTaP, Varicella, IPV, PCV, MCV4, Tdap, Hep. A, Rotavirus, HPV) | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) | Has this person had a convulsion (seizure) or is this person suspected to have a disease or problem of the brain or nervous system? (DTaP, Tdap) | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) | Is this person taking a drug or undergoing a treatment that lowers the body's resistance to infection (such as cortisone, prednisone, or certain anticancer drugs) or irradiation? (MMR, Varicella, Rotavirus) | <input type="checkbox"/> | <input type="checkbox"/> |
| 5) | Does this person have cancer, leukemia, lymphoma, HIV/AIDS or a disease that lowers the body's resistance to infection? (MMR, Varicella, Rotavirus) | <input type="checkbox"/> | <input type="checkbox"/> |
| 6) | Has this person had a serious reaction to a product containing thimerosal, a mercurial antiseptic (usually found in eye drops)? (Td) | <input type="checkbox"/> | <input type="checkbox"/> |
| 7) | Has this person had an allergic reaction to a vaccine containing diphtheria toxoid so serious that it required medical treatment? (Hib, Td, DTaP, PCV, MCV4, Tdap) | <input type="checkbox"/> | <input type="checkbox"/> |
| 8) | Is this person allergic to an antibiotic called 1) Neomycin 2) Streptomycin or 3) Polymyxin B or allergic to 4) gelatin 5) yeast 6) 2 - Phenoxyethanol 7) aluminum? (MMR - 1,4; Varicella - 1,4; Hep B - 5; IPV - 1,2,3; Hep. A - 1,6,7; HPV - 5,7) | <input type="checkbox"/> | <input type="checkbox"/> |
| 9) | Has this person received gamma globulin or blood products within the preceding several months? (MMR, Varicella, Rotavirus) | <input type="checkbox"/> | <input type="checkbox"/> |
| 10) | Is the person receiving immunizations pregnant? (MMR, Td, Varicella, MCV4, HepA, HPV); (Hep B, IPV, Tdap - refer to PMP) | <input type="checkbox"/> | <input type="checkbox"/> |
| 11) | Has this person received immunizations in the last four weeks? (MMR, Varicella, Rotavirus) | <input type="checkbox"/> | <input type="checkbox"/> |
| 12) | Does this person have known allergic reactions (generalized hives, wheezing, swelling of mouth and throat, difficulty breathing, hypotension & shock) to dry natural rubber latex? (MCV4, Comvax, Td, PCV, Tdap - Boostrix prefilled) | <input type="checkbox"/> | <input type="checkbox"/> |
| 13) | Does this person have a history of Guillain-Barre' Syndrome (GBS)? (MCV4, Tdap) | <input type="checkbox"/> | <input type="checkbox"/> |
| 14) | Has this person ever had a low platelet count (a blood disorder)? (MMR) | <input type="checkbox"/> | <input type="checkbox"/> |
| 15) | Does this person have a preexisting chronic gastrointestinal disease or has this person ever had intussusception (bowel obstruction)? (Rotavirus) | <input type="checkbox"/> | <input type="checkbox"/> |
| 16) | Has this person ever had chicken pox disease or chicken pox vaccine? (Varicella) | <input type="checkbox"/> | <input type="checkbox"/> |

I give the Lee County Health Department permission to provide an immunization record to the parent/guardian/accompanying adult and/or the person's doctor listed below, and/or other collaborating medical service providers, childcare centers/preschools, Head Start, schools, and/or insurance companies.

Doctor's Name: _____

X _____
 Signature of Parent, Guardian or Accompanying Adult Relationship Phone