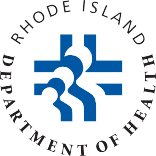
**Vaccine Consent Form**

**Patient Information** *Please print.*

Last Name: First Name: Date of Birth / /

MM DD YEAR

Address: City: State: ZIP:

Phone Number: Preferred Language:  English  Other:

Sex Assigned at Birth:  Male  Female

|  |  |  |  |
| --- | --- | --- | --- |
| (*optional*) Gender Identity: |  Cisgender (same as sex assigned at birth) |  Gender Non-Conforming/Non-Binary |  Transgender |
|  |  Other |  Prefer not to answer |  |

Race (select):  American Indian or Alaska Native  Asian  Black  Native Hawaiian and Pacific Islander  White

 Some Other Race  Prefer not to answer

Ethnicity (select):  Hispanic or Latino  Not Hispanic or Latino  Unknown  Prefer not to answer

Immigration Status:  Refugee Humanitarian Parolee  Asylee  Special Immigrant Visa (SIV) Legal Permanent Resident (LPR)

 Unknown  Prefer not to answer  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Name (if applicable): Daytime Phone: Insurance Company: Member ID: Group # (if applicable):  No Insurance *(no charge)*

**Routine Vaccine Eligibility Screening** *Patients must complete this section.*

*Answering “YES” may exclude a patient from getting a certain vaccine. The nurse will review answers to determine eligibility.*

|  |  |  |
| --- | --- | --- |
| 1. Do you have allergies to medicine, food, a vaccine component, or latex? | Yes  | No  |
| 2. Have you had a serious reaction to a vaccine in the past? | Yes  | No  |
| 3. Do you have a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak? | Yes  | No  |
| 4. Are you on long-term aspirin therapy? | Yes  | No  |
| 5. Have you, a sibling, or a parent had a seizure? | Yes  | No  |
| 6. Have you had a brain or other nervous system problem? | Yes  | No  |
| 7. Have you ever been diagnosed with a heart condition (myocarditis or pericarditis) or Multisystem Inflammatory Syndrome (MIS-C) after an infection with the virus that causes COVID-19? | Yes  | No  |
| 8. Do you have cancer, leukemia, HIV/AIDS, or any other kind of immune system issue? | Yes  | No  |
| 9. In the past six months, have you taken any medications that affect the immune system such as prednisone or other steroids, anticancer drugs; drugs to treat rheumatoid arthritis, Crohn’s disease, or psoriasis; or had radiation treatments? | Yes  | No  |
| 10. Do your parents or sibling(s) have an immune system problem? | Yes  | No  |
| 11. In the past year, have you received immune (gamma) globulin, blood/blood products, or an antiviral drug? | Yes  | No  |
| 12. Have you received any vaccinations in the past four weeks?  Please list | Yes  | No  |
| 13. Have you ever felt dizzy or faint before, during, or after a shot? | Yes  | No  |

Name:

**Vaccine Requested** *Please sign and date.*

**HEP B DATE: \_\_\_**

**MMR DATE: \_\_\_**

**MENINGITIS DATE: \_\_\_**

**POLIO DATE: \_\_\_**

**TDAP/TD DATE: \_\_\_**

**VARICELLA DATE: \_\_\_**

**HEP A DATE: \_\_\_**

**COVID-19 DATE: \_\_\_**

**DATE OF LAST COVID VACCINE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

