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ADULT IMMUNIZATION QUESTIONNAIRE

Date:____/____/________ **Name - Last:** _________________________ **First:** _________________________ **MI:** __________

Address: _____________________________________ **City:**_______________________ **State**________ **Zip**______________

Phone # ________________________ **Birth Date:**____/____/________ **Age:**____ **Sex:** **Male** **Female**

Social Security # ____________________________

Ethnicity: Hispanic or Latino Non Hispanic or Latino

Race: Amer.Indian/Alaskan Native Asian White Black/African Amer. Native Hawaiian or Other Pacific Islander

Patient/Guardian Name (Print) Last:______________________________ **First:** __________________________**MI:**___________

I have been given a copy and have read, or had explained to me, the information in the "Vaccine Information Statement(s)," where applicable, for the vaccine(s) indicated below. I have had a chance to ask questions and had them answered to my satisfaction. I understand the benefits and risks of the vaccine(s) requested and ask that the vaccine(s) currently due for which I have signed below be given to me or to the person named above for whom I am authorized pursuant to Section 431.058, RSMo to make this request.

Patient / Guardian Signature:____ **Date:**_________________________________

		Circle correct response	
1.	**Does the person receiving the vaccine:**		
a)	currently have an illness more serious than a cold (fever, ear infection, diarrhea, vomiting)?	YES	NO
b)	have contact with someone who is HIV positive?	YES	NO
c)	have contact with someone who is receiving treatment for cancer or who has deficiency of the immune system?	YES	NO
d)	have a personal or family history of convulsions, seizures, tuberculosis or Guillan-Barre Syndrome	YES	NO
e)	have contact with someone who has not had any vaccinations?	YES	NO
2.	**Has the person receiving the vaccine:**		
a)	had a reaction to a vaccine other than redness, soreness and swelling in the injection site?	YES	NO
b)	taken a drug that affects the immune system (such as immune globulin or steroids) in the last 3-6 months?	YES	NO
c)	had an allergic reaction to:		
	a medication (name of medication___________________________)	YES	NO
	thimerosal (a preservative)	YES	NO
	latex	YES	NO
	Eggs/chicken	YES	NO
	gelatin	YES	NO
	Flu shot	YES	NO
d)	had a high fever or other serious reaction to a previous dose of vaccine?	YES	NO
e)	tested positive for HIV?	YES	NO
f)	ever had Chicken Pox (Varicella)? Actual disease or Vaccine	YES	NO
3.	**Is the person receiving the vaccine pregnant?**	YES	NO
4.	**Has the person being immunized received any vaccines in the last month?**	YES	NO

Nurse Use Only

immunization status reviewed.
No true contraindications to vaccinations per Immunization questionnaire/interview
Potential side effects reviewed. Encouraged to contact LCH with q uestions and concerns.
Vaccination information statements given to parents
Discussed dosage & use of Tylenol to manage side effects.
Vaccines recorded on vaccination card.

Return ____________________________________

PER PROTOCOL ORDER SIGNED ___________________ DATE:_____________