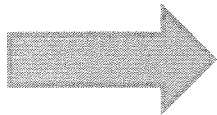


Last	First	Middle	Sex M F	Race	Birth Date	Age
Address		City	State	Zip	County	Phone
Mother's Name		Mother's Maiden Name	Father's Name		Name of Child's School	

**Please
Complete
these
health
questions:**



SCREENING

1. Is Child **sick** Today? Yes No
2. Does Child have **allergies** to medications, food, vaccine or latex? Yes No
3. Has Child had a **serious reaction** to a vaccine? Yes No
4. Does/Has Child have health problems like **Diabetes, Asthma, Lung, heart or kidney disease, blood disorders, Cancer, AIDS**, any other **major health problems** or on long term **aspirin therapy**? Yes No
5. If the child to be vaccinated is between the ages of 2 and 4 years, has a health care provider told you that the child had **wheezing or asthma** in the past 12 months? Yes No
6. Has Child had a **seizure** or a **brain disorder**? Yes No
7. Has Child taken cortisone, prednisone, or other **steroids** or **anti-cancer drugs** or had **radiation treatments** in the past 3months? Yes No
8. Has Child received a **transfusion** of blood or blood products or been given immune (gamma) globulin in the past year? Yes No
9. Is the Child/Teen **pregnant** or is there a chance she could become pregnant during the next month? Yes No
10. Has the Child had vaccines/**shots in last 4 weeks**? Yes No
11. Has the Child had **Chickenpox**, if so when? Mth/ Yr _____ No

Screener Signature _____

CONSENT

I received or was offered a copy of the Vaccine Information Statement (VIS) for each vaccine. I know the risks of the disease each vaccine prevents. I know the benefits and risks of each vaccine. I have had a chance to ask questions about the disease, the vaccines, and how the vaccines are given. I know that the person receiving the vaccine will have the vaccine put into his/her body to prevent the infectious disease. I am an adult who can legally consent for the person named above to get the vaccine. I freely and voluntarily give my signed permission for the vaccines.

Parent/Guardian Signature

Date

Relationship to Child

Date Given	Vaccine Given	Mfg	Lot #	Site Used	VIS Date	Adm. Initials
	Rotavirus 6-32wks <i>Do not start after 12 weeks</i>	GSMK Merck			E:12/06/10	
	Pediarix 6wk-6y <i>DTAP Hep B IPV</i>	GSMK			See individual VIS	
	Pentacel 6wk-5y <i>DTAP IPV HIB</i>	Sanofi			See individual VIS	
	HIB <5y	Sanofi			12/16/98	
	PCV-13 <5y	Wyeth			E: 4/06/10	
	HEP B 0-18y	GSMK Merck			7/18/07	
	DT 6wk-6y <i>Hx seizures</i>	Sanofi			5/17/07	
	KINRIX 4-6y <i>5th DTAP AND 4th IPV only</i>	GSMK			See individual VIS	
	DTAP 6wk-6y	GSMK Sanofi			5/17/07	
	IPV 6wk-18y	Sanofi			1/1/00	
	MMR 1-18y	Merck			3/13/08	
	MMRV 1-12 y	Merck			5/21/10	
	Varicella 1-18y	Merck			3/13/08	
	HEP A 1-18y	GSMK Merck			3/21/06	
	Td 7-10y <i>or Hx of Seizures</i>	Sanofi			E: 11/18/08	
	Tdap 11-12y <i>or 7-10y under vaccinated</i>	GSMK Sanofi			E: 11/18/08	
	HPV 9-18y	GSMK MERCK			3/30/10	
	MCV4 11-18y <i>or 5y booster</i>	Sanofi			1/28/08	
	Flu Circle 1 >6mo - <3years OR 3 years and up	Sanofi				
	Flumist 2-18y	Medimmune				

Administrator's Signature _____

***Notes** _____