INFORMATION ABOUT PERSON TO RECEIVE VACCINE (PLEASE PRINT)

Clients Legal Name: Last First MI	Birth date	Sex	Age

Address	City	State	Zip

Phone #	Physician Name:

RACE: *(circle all that apply)* White Hispanic African American Asian Pacific Islander American Indian

ETHNICITY: *(circle all that apply)* White Hispanic African American Mixed Race

Yes	No	
☐	☐	1. Is the client sick today?
☐	☐	2. Is the client allergic to eggs, baker's yeast, neomycin, sorbitol, latex or any vaccines?
☐	☐	3. Has the client had a serious reaction to any vaccine in the past?
☐	☐	4. Does the client have uncontrolled epilepsy or a history of seizures that have not been evaluated by a doctor, or other neurological problems?
☐	☐	5. Does the client have cancer, leukemia, AIDS or any other immune system problem, or take cortisone, prednisone, other steroids, anticancer drugs or x-ray treatments?
☐	☐	6. Has the client received a transfusion of blood, plasma or a medicine called immune globulin in the past year?
☐	☐	7. Is the client pregnant or at risk for becoming pregnant within the next three months?
☐	☐	8. I received a copy of the VFC information sheets with possible effects that could be caused from the vaccine(s).

"I have read or have had explained to me by the nurse the VIS about the vaccine and all components that will be administered. I understand the potential contraindications to receiving the vaccine. My questions have been answered and I understand the risks and benefits of the vaccine and all the various vaccine components. I give my consent for the vaccine and all the various components to be administered to me or to the person named for whom I am authorized to make this request."

I authorize the release of the immunization record to my physician. I understand that HIPPA releases must be signed to release immunization information to other providers such as schools, Head Start and daycare facilities. YES __________ NO __________

Signature of person to receive vaccine or person authorized to make requests.

X____ **Date**____________________

(Patient/Parent/Legal Guardian Adult Accompanying Child)

DATE VFC INFORMATION SHEETS GIVEN:______________

VFC Information Forms: HPV__________

Revised 8/26/2013 pink

HPV #1

Date Administered:________________________________

MFR/LOT#

Site of Injection_______________

Nurse Signature:

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HPV #2

Date Administered:________________________________

MFR/LOT#

Site of Injection_______________

Nurse Signature:

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HPV #3

Date Administered:________________________________

MFR/LOT#

Site of Injection_______________

Nurse Signature:

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Comments:

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Livingston County Public Health Department
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____ N/C ___Cash ___Check Public Aid #________________ Credit Card #____________________