INFORMATION ABOUT PERSON TO RECEIVE VACCINE (PLEASE PRINT)

MUST BE ***LEGAL*** NAME Last First Middle	Birth date	Sex	Age
Address City State Zip	Last 4 digits of your Social Security Number:		
Phone #	Physician Name:		

RACE: *(circle all that apply)* White, American Indian/Alaska Native, Asian, Black/African American, Native Hawaiian/other

ETHNICITY: *(circle all that apply)* White Non-Hispanic, White Hispanic, Asian, Black Hispanic, Black Non-Hispanic, 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?

"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 request that Livingston County Health Department (LCHD) bill my insurance/Medicare/Medicaid policy for services rendered and authorize the payment of benefits be made on my behalf to LCHD for those services. I understand that I am responsible for payment for any deductible, co-pays, or any non-covered service furnished. In the event of non-coverage, financial arrangements can be made with LCHD.

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

X______________________________________ **Date**____________________

(Patient/Parent/Legal Guardian Adult Accompanying Child)

X______________________________________ **Date of Birth**________________

PRINT NAME LEGIBLY RELATIONSHIP TO PATIENT Responsible Parent or Guardians

DATE VIS SHEETS GIVEN:______________

VIS Forms Dated: IPV__________ Heb B__________ Dtap__________ Tdap/TD__________ Chicken Pox__________ Meningitis__________

Hep A__________ MMR__________ Typhoid__________ Yellow Fever__________ Shingles__________ Hib__________ Pnuemococcal__________

Rotovirus__________

Revised 4/8/2016 blue