THAYER COUNTY HEALTH SERVICES VACCINE ADMINISTRATION FORM

I have been given a copy and have read or have had explained to me the information in the Vaccine Information Statement (s) for the disease(s) and vaccines(s) circled below. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) requested and ask that the vaccine(s) circled below be given to me or the person named below for whom I am authorized to make this request. I accept responsibility for seeking medical attention for any adverse reactions that may arise as a result of receiving the vaccine(s).

Vaccine Date:	**Circle one of the following below:**
Child's name:	1) Insurance covers vaccines -TCHS vaccine used
Date of Birth:	2) Native Alaskan, American Indian -VFC vaccine used
Signature:	3) No Insurance -VFC vaccine used
(Parent or Guardian)	4) Medicaid-VFC vaccine used
	5) Underinsured -VFC vaccine used

1. Is the child sick today?	YES	NO	UNSURE
2. Does the child have allergies to medications, food, a vaccine component, or latex	YES	NO	UNSURE
3. Has the child had a serious reaction to a vaccine in the past?	YES	NO	UNSURE
4. Has the child had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy?	YES	NO	UNSURE
5. If the child to be vaccinated is 2 through 4 years of age, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	YES	NO	UNSURE
6. If your child is a baby, have you ever been told he or she has had intussusception	YES	NO	UNSURE
7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	YES	NO	UNSURE
8. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system prc	YES	NO	UNSURE
9. In the past 3 months, has the child taken medications that weaken their immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments?	YES	NO	UNSURE
10. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	YES	NO	UNSURE
11. Is the child/teen pregnant or is there a chance she could become pregnant durir the next month?	YES	NO	UNSURE
12. Has the child received vaccinations in the past 4 weeks?	YES	NO	UNSURE

VACCINE ADMINISTRATION RECORD FOR CLINIC USE ONLY

VACCINE and VACCINE INFORMATION STATEMENTS USED:

DTaP (05-17-07)	HIB (02-04-14)	Hep A (10-25-11)	Tdap (05/09/13)	HPV (05-17-13)	
Hep B (02-02-12)	PCV13 (02-27-13)	MMR (04-20-11)	Meningococcal (10-14-11)		
IPV (11-08-11)	Rota (08-26-13)	Varicella (03-13-08)	Td (2/4/14)	Influenza (07-26-13)	

Vaccine manufacturer used for the following vaccines:	
Sanofi Pasteur: ActHib, Adacel, MCV4, Pentacel, IPOL	Merk: MMR, Recomivax Ped, Rotatiq, Varivax, HPV
GSK: Havrix 2dose, Pediarix, Kinrix, Boostrix, Infarix	Pfizer/Wyeth: PCV13

1.) Vaccine	Date Received:	Vaccine Manufacturer/Lot# :
Vaccine Exp. Date:	Injection Si	Rt Deltoid SQ/ Lt Deltoid SQ--Rt Deltoid IM/Lt Deltoid IM
Nurse Signature:	Rt Thigh SQ/Lt Th	igh SQ--Rt Thigh IM/Lt Thigh IM
2.) Vaccine	Date Received:	Vaccine Manufacturer/Lot# :
Vaccine Exp. Date:	Injection Site: Rt Deltoid SQ / Lt Deltoid SQ--Rt Deltoid IM / Lt Deltoid IM	
Nurse Signature:	Rt Thigh SQ/Lt Th	igh SQ--Rt Thigh IM/Lt Thigh IM