ALLEN COUNTY PUBLIC HEALTH
"PLEASE PRINT"

Complete Information about person to receive vaccine **************"PLEASE PRINT"*************			DATE:		NEW CLIENT: YES__ NO____
Name: Last	First:	Middle Initial:	Date of Birth:		Age today:
Mailing Address: Apt. #/Lot#	City:		State:	Zip Code:	Township:
Phone Number:		Race:		Sex: Male Female	
Social Security Number:		Client's Doctor:			
Parent or Legal Guardian's Name: (for client under 18yrs. of age					

PRE-VACCINE QUESTIONNAIRE

Has the person receiving shots today:	YES	NO
Been ill in the last 24 hours or had fever over 100 degrees In the last 24-48 hours?		
Had any problems with previous immunizations?		
Have any allergies to latex, food or medicine, including eggs or egg products, gelatin, streptomycin, neomycin or thimerosal (in contact lens solution)? If yes, list allergy here:		
Have any immune system problems such as cancer, leukemia, HIV/AIDS, or close contact with a person whose immune system is compromised?		
Taken any medications in the last 3 mo. that weaken their immune system, such as cortisone, prednisone, other steroids, or anticancer drugs or had radiation treatments?		
Received blood products, transfusion, immune globulin, or antiviral drugs in the last year?		
Received any vaccines in the last 28 days?		
Pregnant or a chance of becoming pregnant in the next month?		
Or mother ever been diagnosed with Hepatitis B?		
Had a health problem with the lungs, heart, kidney or metabolic disease (e.g. diabetes, asthma, liver disease, sickle cell, or other blood disorders or on aspirin therapy?		
Have history of asthma, reactive airway disease or wheezing?		
Ever been diagnosed with Guillain-Barre Syndrome?		
Ever been told he or she has had intussusception?		
Or sibling or parent had a seizure, or other brain or nervous system disorder?		
Taken antibiotics or antiviral medications within the last 24 hours?		

Answer the following questions if pregnant or someone in your household is under age 4 years:

Are you currently on WIC?		
Would you like to be referred to WIC?		

I have read or have had explained to me the information contained in the Vaccine Information Statement(s) about the vaccine(s). I have had the chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s), and ask that the vaccine(s) be given to me, or the person named for whom I am authorized to make this statement.

I grant permission for this record to be released to the Ohio Dept. of Health, medical providers, health departments, schools, daycare centers and as the law requires.

Signature required of person to receive vaccine or person authorized to make the request, if client is less than 18 years of age:

Name: ______________________________ Date: ____________

*****STOP HERE!*****

STOP HERE! THIS SIDE TO BE FILLED OUT BY STAFF ONLY:

PATIENT ELIGIBILITY SCREENING RECORD (Vaccines for Children Program)

1. Is this Client enrolled in Medicaid? Yes__________ No____________
2. Does this client have Health Insurance? Yes__________ No____________
3. Is client an Alaskan native or A Native American Indian? Yes__________ No____________
4. VFC Qualified? Date_________ Yes__________ No____________
5. VIS Given? Yes__________ No____________

VACCINE	DATE GIVEN	MANUFACTURER	LOT NUMBER	INJECTION SITE	VIS DATE	ADMINISTERED BY:
Pediarix (IPV-Dtap-Hep B)	/ /			LT RT LD RD	10-15-2021	
Pentacel (IPV-Dtap-HIB)	/ /			LT RT LD RD	10-15-2021	
Vaxelis (IPV-Dtap-HIB-Hep B)	/ /			LT RT LD RD	10-15-2021	
IPV	/ /			LT RT LD RD	8-6-2021	
Kinrix (IPV-Dtap)	/ /			LT RT LD RD	8-6-2021	
Quadracel	/ /			LT RT LD RD	8-6-2021	
Dtap / DT	/ /			LT RT LD RD	8-6-2021	
Td / Tdap	/ /			LT RT LD RD	8-6-2021	
HIB	/ /			LT RT LD RD	8-6-2021	
HPV 9	/ /			LD RD	8-6-2021	
HEP-B	/ /			LT RT LD RD	10-15-2021	
HEP-A	/ /			LT RT LD RD	10-15-2021	
MMR	/ /			LA RA	8-6-2021	
VARICELLA	/ /			LA RA	8-6-2021	
Proquad (MMR-VAR)	/ /			LA RA	8-6-2021	
Rotovirus	/ /			O	10-15-2021	
Prevnar 13	/ /			LT RT LD RD	2-4-2022	
Prevnar 15	/ /			LT RT LD RD	2-4-2022	
Pneumovax 23	/ /			LT RT LD RD	10-30-2019	
Meningococcal (ACWY)	/ /			LT RT LD RD	8-6-2021	
Men B (Bexsero)	/ /			LD RD	8-6-2021	
Flu (6 mo.-18 yrs)	/ /			LT RT LD RD	8-6-2021	

NURSE COMMENTS:____

NEXT RETURN DATE: ____________________