

REQUEST FOR VACCINATION(S)/LAB/HIV TESTING - CONSENT FORM

The IMUnization Clinic will keep this record in you or your child's medical file. It records what vaccine(s) and/or test(s) were given, the date when the vaccine(s) and/or test(s) were given, the name of the company that made the vaccine(s) and/or test(s), the lot number of the vaccine(s) and/or test(s), and the address where the vaccine(s) and/or test(s) were administered. By signing the form below, you hereby freely and voluntarily give your permission and are requesting that the vaccine(s) and/or test(s) indicated by your signature(s) below be given to you or the person named below for whom you are authorized to make this request. The IMUnization Clinic will give you a "Vaccine Information Sheet" on each vaccine, or a "Subject Information" pamphlet on each test, as stated by law, for you to read BEFORE you receive your shots and/or test(s). Your signature below indicates that you have read, or have had the information explained to you and that you understand the benefits and risks of each vaccine administered. You hereby release and agree to hold harmless The IMUnization Clinic, its Officers, and Employees for any and a ll liability, of any kind or nature whatsoever, which might arise out of or result from any vaccine(s) and/or test(s) administered to you or your child.

PLEASE PRINT ALL ENTRIES CLEARLY

Last Name _____ First Name _____ Middle Initial _____
 Street Address _____ City _____, St. _____ Zip _____
 Telephone _____ DOB _____ Age _____ Email: _____
If Person receiving vaccine/HIVtesting is under 18, PRINT parent's/guardians name in this space:
 Mother's/Legal Guardian Maiden Name _____
 Father's Name _____

RACE/SEX: Please check the box that applies to the person being immunized/tested:

- Asian Male Black Male Hispanic Male Oriental Male Other Male White Male
 Asian Female Black Female Hispanic Female Oriental Female Other Female White Female

ALLERGIES: _____ **Signature of Vaccine Administrator :** _____

Signature (s):	X	Vaccine/Test	1 st Date	2 nd Date	3 rd Date	Route	Manuf.Co.	Lot#	Site	VIS Form
		Drug Test					Sent to:	Quest		N/A
		Dtap/ DT					SP /			05/17/07
		HPV					M/GSK			05/03/11
		Hepatitis A					M / GSK			03/21/06
		Hepatitis B					M / GSK			07/18/07
		Hib					SP			12/16/98
		Influenza injection								08/10/10
		Influenza nasal								08/10/10
		IPV (polio)					SP			01/01/00
		Jap. Encep.								03/01/10
		Kinrix [Dtap/IPV]					GSK			05/17/07-1/1/00
		Meningitis					SP			01/28/08
		MMR					Merck			03/13/08
		MMR/V [proquad]					Merck			05/21/10
		PediarixDtap/HepB/IPV					GSK			09/18/08
		Pentacel Dtap/Hib/IPV					SP			09/18/08
		Pneumonia					Merck			10/06/09
		PCV7					Wyeth			04/16/10
		Rabies					SP/CH			10/06/09
		Rotavirus					Merck			12/06/10
		Td/Tdap					SP/			07/12/06
		Typhoid					SP / Ber.			05/19/04
		Twinrix					GSK			3/21/06-7/11/01
		Varicella					Merck			03/13/08
		Yellow Fever					SP			03/30/11
		Zostavax/Shingles					Merck			10/06/09
		Lab Titer Testing					Sent to:	Quest		N/A
		HIV								N/A
		PPD Skin Test	Given	//	Read	mm	Aventis			N/A
		PPD Skin Test	Given	//	Read	mm	Aventis			N/A

IMU Southwest
The IMUnization Clinic

**SCREENING QUESTIONNAIRE FOR CHILD/ADOLESCENT/ADULT IMMUNIZATION
ADMINISTRATION**

PATIENT NAME: _____

DATE OF BIRTH: _____

The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions may be asked. If a question is not clear, please ask and we will explain it to you.	YES	NO	DON'T KNOW
Are you [the patient] sick today?			
Do you [the patient] have any allergies to medications, food, or any vaccine? If yes, please list:			
Have you [the patient] ever had a serious reaction after receiving a vaccination? If yes, please explain:			
Do you [the patient] have cancer, leukemia, AIDS, or any other immune system problem? If yes, please list:			
Do you [the patient] take cortisone, prednisone, other steroids, or anticancer drugs, or have you had x-ray treatments?			
Do you [the patient] have a seizure, brain, or nerve problem? If yes, please explain:			
During the past year, have you [the patient] received a transfusion of blood or blood products, or been given a medicine called immune [gamma] globulin?			
Have you [the patient] received any vaccinations in the past 4 weeks?			
For Women: Are you pregnant or is there a chance you could become pregnant during the next month?			
For Women: Have you had a mastectomy or any lymph node removal? If yes, please explain [indicate left or right side]:			
Did you bring your immunization shot record/card with you today?			

How did you hear about us?: _____

Would you like an email reminder for follow-up appointment(s)?

If Yes, please list email address: _____

FORM COMPLETED BY: _____

DATE: _____



Clinic/Site Location: 3727 Greenbriar Dr. #403 Stafford, TX 77477



RELEASE OF LIABILITY FORM/ PRIVACY PRACTICES ACKNOWLEDGEMENT

I have been given information regarding the side effects, risks, and benefits to receiving the vaccine(s) and/or test(s) I am requesting today for myself, or my child. I hereby release and agree to hold harmless IMU Southwest, the IMUnization Clinic, its Officers, and Employees from any and all liability, of any kind or nature whatsoever, which might arise out of or result from any vaccine(s) and/or test(s) administered to me or my child.

If in the event a life threatening adverse reaction or side effect should occur, please obtain medical care FIRST. Notify the IMUnization Clinic after obtaining medical care so that it can properly be reported through the Vaccine Adverse Event Report System [VAERS] immediately, as required by state law (Texas Department of Health Form C-76).

The privacy of your medical information is important to us and we are committed to protecting it. The IMUnization Clinic will not use or disclose your medical information without your specific written authorization, unless deemed necessary for billing or legal purposes. Any specific written authorization you provide may be revoked at any time by a written notice from you to us. If you have any questions or think that we may have violated your privacy rights, please contact us.

Signature

Date

Witness _____

Date _____
