IMU Southwest

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 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 you or your child.

PLEASE PRINT ALL ENTRIES CLEARLY

Last Name ____________________________ First Name __________________________ Middle Initial ______

Street Address ____ City _______________, St. ______ Zip _________

Telephone ___________________ Date of Birth _______________ Age ___________

If Person receiving vaccine/HIV testing is under 18, **PRINT** parent's/guardians name in this space:

Mother's Maiden Name ___________________________ Father's Name _________________________________
Legal Guardian _________________________________

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	2	3	4	5	Manuf.Co.	Lot #	Site	VIS/Info Form
	01		Drug Test	/ /	/ /	/ /	/ /	/ /	Sent to:	Quest		N/A
	02		Dtap / DT	/ /	/ /	/ /	/ /	/ /	SP / GSK			05/17/07
	03		HPV	/ /	/ /	/ /	/ /	/ /	M / GSK			03/30/10
	04		Hepatitis A	/ /	/ /	/ /	/ /	/ /	M / GSK			03/21/06
	05		Hepatitis B	/ /	/ /	/ /	/ /	/ /	M / GSK			07/18/07
	06		Hib	/ /	/ /	/ /	/ /	/ /	SP			12/16/98
	07		Influenza - injectable	/ /	/ /	/ /	/ /	/ /				08/10/10
	08		Influenza - nasal	/ /	/ /	/ /	/ /	/ /	MedImm.			08/10/10
	09		IPV (polio)	/ /	/ /	/ /	/ /	/ /	SP			01/01/00
	10		Jap. Encep.	/ /	/ /	/ /	/ /	/ /				03/01/10
	11		Kinrix [Dtap/IPV]	/ /	/ /	/ /	/ /		GSK			05/17/07-1/1/00
	12		Meningitis	/ /	/ /	/ /	/ /	/ /	SP			01/28/08
	13		MMR	/ /	/ /	/ /	/ /	/ /	Merck			03/13/08
	14		MMR/V [proquad]	/ /	/ /	/ /	/ /	/ /	Merck			05/21/10
	15		Pediarix Dtap/HepB/IPV	/ /	/ /	/ /	/ /	/ /	GSK			09/18/08
	16		Pentacel Dtap/Hib/IPV	/ /	/ /	/ /	/ /	/ /	SP			09/18/08
	17		Pneumonia						Merck			10/06/09
	18		PCV13	/ /	/ /	/ /	/ /	/ /	Wyled			04/16/10
	19		Rabies	/ /	/ /	/ /	/ /	/ /	SP / CH			10/06/09
	20		Rotavirus	/ /	/ /	/ /	/ /	/ /	Merck			05/14/10
	21		Td / TdaP	/ /	/ /	/ /	/ /	/ /	SP / GSK			11/18/08
	22		Typhoid	/ /	/ /	/ /	/ /	/ /	SP / Ber.			05/19/04
	23		Twinrix	/ /	/ /	/ /	/ /	/ /	GSK			3/21/06-7/11/01
	24		Varicella	/ /	/ /	/ /	/ /	/ /	Merck			03/13/08
	25		Yellow Fever	/ /	/ /	/ /	/ /	/ /	SP			11/09/04
	26		Zostavax/Shingles	/ /	/ /	/ /	/ /	/ /	Merck			10/06/09
	27		Lab Titer Testing		/ /		/ /		Sent to:	Quest		N/A
	28		HIV	/ /	/ /	/ /	/ /	/ /				N/A
	29		PPD Skin Test	Given	/ /	Read	/ /	mm	Aventis			N/A
	30		PPD Skin Test	Given	/ /	Read	/ /	mm	Aventis			N/A

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

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SCREENING QUESTIONNAIRE FOR CHILD/ADOLESCENT/ADULT IMMUNIZATION ADMINISTRATION

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?			

PATIENT NAME: ______________________ **DATE OF BIRTH:** ______________

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:** ____________________

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SCREENING QUESTIONAIRE FOR INTERNATIONAL TRAVEL

Medical History of: (your name) ______________________________
Occupation: ______________________ Email Address: ______________________

Primary Physician: ______________________ Telephone: ______________________
Office Address: ______________________________
City: ______________ State: ______________ Zip Code: ______________

Should we send a copy of your Immunization record to your Primary Physician?
Yes __________ No __________

Destination of Travel:

1. Where are you going? [Please list countries and areas within countries, rural vs. urban]:

____

2. Date of Departure: ______________ Date of Return: ______________

3. Purpose of Travel: Business ____ Pleasure _______ Mission Study _ Service ______

4. Name of Church or Business Affiliation for the trip: ______________________
Address: ______________________________

Health History:

Allergies: ______________________________
Weight: ______________ Height: ______________

Medications: [*Please list all medications currently being taken*]

Prescription: ______________________________
Non Prescription: ______________________________

Medical Conditions: ______________________________

____

Previous Surgery(s): ______________________________

____

Check Nightmares☐if you have present or past history of the following: Psoriasis☐ Psychiatric Disorders/Depression☐ Seizures/Epilepsy☐ Stomach/Colon☐ Problems

I verify that the above information is complete and correct to the best of my knowledge:

Signature: ______________________ Date: ______________________
Reviewed by: ______________________ Date: ______________________

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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 Foundation, 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**

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