

## The IMUnization Clinic

### **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, <b>PRINT</b> 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:***

- |                                       |                                       |  |  |                                       |                                       |
|---------------------------------------|---------------------------------------|--|--|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Asian Male   | <input type="checkbox"/> Black Male   | <input type="checkbox"/> Hispanic Male   | <input type="checkbox"/> Oriental Male   | <input type="checkbox"/> Other Male   | <input type="checkbox"/> White Male   |
| <input type="checkbox"/> Asian Female | <input type="checkbox"/> Black Female | <input type="checkbox"/> Hispanic Female | <input type="checkbox"/> Oriental Female | <input type="checkbox"/> Other Female | <input type="checkbox"/> 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	PediarixDtap/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

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

<input type="checkbox"/> 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:** \_\_\_\_\_



## SCREENING QUESTIONNAIRE 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: \_\_\_\_\_

**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