Patient Information

Name:	Phone #:		
Address:	Date of Birth: Month Day Year		
City:	State:	Zip:	Gender: ☐ F ☐ M

Vaccines

- ☐ Tetanus, Diphtheria, and Pertussis (Tdap)
- ☐ Tetanus, Diphtheria (Td)
- ☐ Diphtheria, Tetanus, and Pertussis (DTaP)
- ☐ Haemophilus Influenza B (Hib)
- ☐ Pneumococcal Polysaccharide Vaccine (PPSV23)
- ☐ Pneumococcal Conjugate (PCV)
- ☐ Hepatitis A (HepA)
- ☐ Hepatitis B (HepB)
- ☐ Human Papilloma Virus (HPV)
- ☐ Meningococcal Conjugate (MCV)
- ☐ Meningococcal (MenB)
- ☐ Measles, Mumps, Rubella (MMR)
- ☐ Polio,Inactivated(IPV)
- ☐ Rotavirus (RV)
- ☐ Varicella (Var)
- ☐ Zoster (Shingrix)
- ☐ Covid 19 Vaccine: _____(Brand)
- ☐ Dtap
- ☐ Hib
- ☐ IPV
- ☐ Other:_____

Combination Vaccines

- ☐ DTaP-HepB-IPV (Pediarix)
- ☐ DTaP-IPV/Hib (Pentacel)
- ☐ DTaP-IPV (Kinrix)
- ☐ DTaP, IPV Hib, Hep B (Vaxelis)
- ☐ Hib-HepB (Comvax)
- ☐ MMRV (ProQuad)
- ☐ HepA-HepB (Twinrix)

Travel Vaccines

- ☐ Typhoid
- ☐ Yellow Fever
- ☐ Other:
- ☐ Japanese Encephalitis
- ☐ Rabies

Influenza Vaccine ☐ Influenza Adult-High Dose ☐ Influenza ☐ FluMist (Intranasal) ☐ Flublok

Influenza Vaccination Screening (all)

Have you ever had an allergic reaction to the influenza vaccine?	☐ Yes	☐ No
Have you ever had a central nervous system disorder (Guillain-barre syndrome, MS, etc)?	☐ Yes	☐ No
Have you ever fainted following a shot or blood draw?	☐ Yes	☐ No
Are you feeling sick today or do you currently have a high fever (100F or higher)?	☐ Yes	☐ No
Do you have a severe allergy to eggs?	☐ Yes	☐ No

FluMist Vaccination Screening (in addition to above questions)

Is the person to be vaccinated younger than age 2 years or older than age 49 years?	☐ Yes	☐ No
If age 2 through 4 years, in the past 12 months, has a healthcare provider told you the child had wheezing or asthma?	☐ Yes	☐ No
Do you have a long-term health problem with heart disease, lung disease (including asthma), kidney disease, neurologic disease, liver disease, or metabolic disease (e.g., diabetes)?	☐ Yes	☐ No
Do you have a cochlear implant, spinal fluid leak, or no spleen; have cancer, leukemia, HIV/AIDS, or any other immune system problem; in the past 3 months, have you taken medications that affect the immune system, prednisone or other steroids, or have you had radiation treatments?	☐ Yes	☐ No
Are you receiving or have recently received influenza antiviral medications?	☐ Yes	☐ No
Is the person to be vaccinated age 6 months through 17 years and receiving aspirin or salicylate-containing medicine?	☐ Yes	☐ No
Are you pregnant or could become pregnant within the next month?	☐ Yes	☐ No
Do you live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation?	☐ Yes	☐ No
Has the person to be vaccinated received any other vaccinations in the past 4 weeks?	☐ Yes	☐ No

Covid Vaccine Screening

1) Does patient currently have a moderate or severe acute illness?	☐ Yes	☐ No
2) Does patient currently have a fever greater than or equal to 100.1°F?	☐ Yes	☐ No
3) Is the patient less than 6 months of age (Pfizer/Moderna) or younger than 18 years of age (Novavax/Janssen)?	☐ Yes	☐ No
4) Has patient received monoclonal antibodies or convalescent plasma in the past 90 days?	☐ Yes	☐ No
5) Does the patient have a known history of severe allergic reaction to any of the components of the COVID-19 vaccine they are to receive?	☐ Yes	☐ No
6) Does patient have a known history of an immediate allergic reaction of any severity after a previous dose or known (diagnosed) allergy to a component of the Covid-19 vaccine.	☐ Yes	☐ No

I have had the opportunity to read the Vaccination Information Statement (VIS) or Emergency Use Authorization (EUA) Fact Sheet relating to the vaccination(s) I have selected to receive. I have had the opportunity to ask questions which were answered to my satisfaction. I understand the risk and benefits of receiving vaccination(s). I understand that as a result of receiving vaccination(s), there is no guarantee that I will achieve immunity, or that I will not experience adverse side effects from vaccination(s). I certify that this form has been fully explained to me, that I have read or had it read to me, and I understand its contents.

Patient / Guardian Signature	Print Name	Relationship to patient	Date	Time ☐ AM ☐ PM

Signature of Vaccine Administrator	Print Name	Title	Date	Time ☐ AM ☐ PM

Vaccine Labels:

MEMORIAL HERMANN Medical Group

Vaccination Screening and Consent

66978 (9/22)