



# SOUTHERN ORANGE COUNTY PEDIATRIC ASSOCIATES

"Great Care for Great Kids"

## ADULT VACCINE CONSENT & WAIVER

Date: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Requested Vaccine(s):  Flu Vaccine  Adacel

### SCREENING QUESTIONNAIRE:

YES

NO

1. Do you have allergies to latex, eggs or thimerosal?  YES  NO
2. Do you have moderate to severe acute illness today?  YES  NO
3. Have you had a tetanus shot in the last two years?  YES  NO
4. Have you had a serious allergic reaction to vaccine components?  YES  NO
5. Have you ever had coma or prolonged seizures, not attributable to an identifiable cause within 7 days of administration of a vaccine?  YES  NO
6. Have you had Guillian Barre' Syndrome?  YES  NO
7. Have you had progressive neurological disorder, such as uncontrolled epilepsy?  YES  NO
8. Have you had a history of Arthus hypersensitivity reaction to a tetanus toxoid containing vaccine?  YES  NO
9. Are you pregnant?  YES  NO

### CONSENT:

I have read or have had explained to Vaccine Information Sheet (VIS) about the above mentioned vaccine(s). I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and request that the above-mentioned be given to me. I received a copy of the Vaccine Information Sheet.

My child's name is: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Signature of person receiving the vaccine: \_\_\_\_\_

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

Manufacturer	Date Given	Exp. Date	Dose	Site	VIS Sheet	Lot #	Back Office

AMOUNT PAID: \$ \_\_\_\_\_ FORM of PAYMENT: \_\_\_\_\_