UT Health Science Center San Antonio

Employee Health and Wellness Clinic
Phone: (210) 567-2788
Fax: (210) 567-2779

Consent for Vaccine Administration

Please read and complete the following information to receive immunizations

Name: *Date of Birth:*

Address: *City:* *State:* *Zip:*

Phone #: (Hm) *(cell)* *Department:*

Allergies to medications or foods: *Badge ID:*

I have read and understand the information given to me regarding the vaccines I will be given today. I believe and understand the benefits and risks of the vaccination(s). I request the identified vaccine(s) to be given to me. I have no conditions, which are contraindications for vaccination. I certify that the information I have provided is true and accurate.

Signature: Date:

TO RECEIVE VACCINATIONS THE CLIENT MUST MEET THE FOLLOWING REQUIREMENTS:

€ TETANUS AND DIPHTHERIA VACCINE (Td), € TETANUS, DIPHTHERIA, PERTUSSIS (TdaP) (sub for 1 Td)

The client:
Has NEVER had a serious allergic reaction or other problems with Td, or any other Tetanus/diphtheria vaccine (DTP, DTaP, TdaP, or DT). Is NOT moderately or severely ill. Has NEVER had a fever (104) w/in 48 hrs after vaccination w/a prior Td, TdaP, or DTaP dose. Has NEVER had a seizure w/in 3 days of receiving a prior Td dose. Has NEVER had a collapse or shock-like state w/in 48 hrs of receiving a Td dose. Has NOT had a Td w/in the last 10 yrs. Caution in latex allergy. TDAP can be given during pregnancy though recommendations are after 20 weeks gestation and the optimal time is after 27 weeks gestation.

Mfr:
Lot#:
Dosage: 0.5ml Route: IM
Site: □ RA □ LA
□ Booster:
Given by: Date

VIS version date: 5/19/2013

€ HEPATITIS B (0, 1-2, 4-6) € HEPATITIS A & B COMBO (0, 1-2, 4-6 <OR> 0, 7 days, 21-30 days, 12 mo)

The client:
Is NOT pregnant or breastfeeding, NOT allergic to yeast, not sensitive to Mercury (Thimerosal), NOT moderately or severely ill, NOT had an allergic reaction to a previous dose of Hepatitis B.

Mfr:
Lot#:
Dosage: 1.0 ml Route: IM
Site: □ RA □ LA
□ 1st Dose:
Given by: Date

VIS version date: 2/2/2012

Mfr:
Lot#:
Dosage: 1.0 ml Route: IM
Site: □ RA □ LA
□ 2nd t Dose > 1 mo
Given by: Date

VIS version date: 2/2/2012

Mfr:
Lot#:
Dosage: 1.0 ml Route: IM
Site: □ RA □ LA
□ 3rd Dose >5mo after 2nd
Given by: Date

VIS version date: 2/2/2012 HEP A VIS date 10/25/2011

€ VARICELLA (Chicken Pox)

The client:
Has NEVER had a severe allergic reaction to gelatin, the antibiotic neomycin, or previous Varicella vaccine. Is NOT moderately or severely ill. Is NOT pregnant. Plan on avoiding pregnancy for 1 month after vaccine. Does NOT have HIV/AIDS, a weakened immune system, cancer, not currently taking steroids, or receiving radiation therapy, no recent blood transfusion.

Mfr:
Lot#:
Dosage: 0.5ml Route: SC
Site: □ RA □ LA
□ 1st Dose:
Given by: Date

VIS version date: 3/13/2008

Mfr:
Lot#:
Dosage: 0.5ml Route: SC
Site: □ RA □ LA
□ 2nd Dose: 4-8wks after 1st
Given by: Date

Vis version date: 3/13/2008

€ MEASLES – MUMPS – RUBELLA (MMR)

The client:
Has NEVER had a severe allergic reaction to gelatin, the antibiotic neomycin, or previous MMR vaccine. Is NOT moderately or severely ill. Is NOT pregnant. Plan on avoiding pregnancy for 4 wks after vaccine. Does NOT have HIV/AIDS, a weakened immune system, cancer, not currently taking steroids, or receiving radiation therapy, no recent blood transfusion. NEVER had a low platelet count.

Mfr:
Lot #
Dosage: 0.5ml Route: SC
Site: □ RA □ LA
□ Booster: Date
Given by:

VIS version date: 4/20/2012

Mfr:
Lot#:
Dosage: 0.5ml Route: SC
Site: □ RA □ LA
□ Booster: Date
Given by:

VIS version date: 4/20/2012

€ TB SKIN TEST – MUST BE READ 48-72 HOURS AFTER ADMINISTRATION (PLEASE INITIAL _____)

Do you currently have any of the following symptoms?	YES	NO	UNKN
Unusual fatigue for more than 2 weeks?			
Weight loss (unrelated to dieting)?			
Loss of appetite for more than 2 weeks?			
Persistent cough for longer than 2 weeks?			
Blood streaked sputum?			
Fever associated with cough for more than 1 week?			
Night sweats?			
Other unusual symptoms?			
Is there a history of TB in your family?			
Have you ever taken Anti-Tuberculin medications?			
Have you ever had "BCG" vaccination?			
Have you had an MMR vaccine in the past 3 months?			
Do you currently have an immune compromised illness?			
Have you ever had a positive TB skin test?			
If YES, WHEN & WHERE?:			

Admin Date: Time:
Placed By:
Mfr:
Lot#
0.1ml/5 TU PPD
Forearm Site: R L
Must be read between 48-72 hours after admin.

Interpretation of Results
Read only area of induration (raised area) not redness
_____**mm induration Neg Pos**

Read Date: Time:
Read By:
Entered in People Soft by:
Date: