CONS1001

VACCINE TO BE ADMINISTERED:

☐ Hepatitis A
☐ Hepatitis B
☐ Hib (haemophilus Influenzae type b)
☐ Influenza
☐ Meningococcal ACWY
☐ Polio
☐ Rabies
☐ MMR
☐ Varicella
☐ HPV
☐ Herpes-Zoster

Tetanus/Diphtheria
☐ DT
☐ Td (greater than 10 years of age)

Tetanus/Diphtheria/Acellular Pertussis
☐ DTaP
☐ Tdap (greater than 10 years of age)

Pneumococcal
☐ PCV13 (generally for < 5 years of age)
☐ PPSV23

☐ Other: _____

1.	Are you currently sick or experiencing a fever?	☐ Yes	☐ No
2.	Have you ever had a serious reaction to a vaccine in the past?	☐ Yes	☐ No
3.	Do you have any allergies that produce a severe (anaphylactic) reaction?	☐ Yes	☐ No
4.	Do you have an allergy or reaction to latex?	☐ Yes	☐ No
5.	Do you have allergies to medications, food, gelatin, eggs, yeast, vaccine preservatives (i.e., Thimerosal)?	☐ Yes	☐ No
6.	Have you been on antibiotics in the last 24 hours?	☐ Yes	☐ No
7.	Do you have any medical problems that make it hard for you to fight infection?	☐ Yes	☐ No
8.	Are you taking cortisone, prednisone, steroids, anti cancer drugs, had radiation treatments?	☐ Yes	☐ No
9.	Have you received blood, plasma, or immune globulin in the past 12 months?	☐ Yes	☐ No
10.	Do you have a history of Guillain-Barre syndrome or have you had a seizure, brain or neurological problem?	☐ Yes	☐ No
11.	During the past 4 weeks have you received any vaccinations?	☐ Yes	☐ No
12.	Are you pregnant or planning to become pregnant in the next 3 months or breastfeeding?	☐ Yes	☐ No
13.	Do you have any long term health problems? (i.e., Heart, lung, kidney disease, diabetes, asthma/wheezing, anemia or other blood disorder)	☐ Yes	☐ No
14.	Do you have any other health condition, history or illness not described above?	☐ Yes	☐ No

If yes, explain: _____

A yes answer to any of the above questions will require approval from a doctor before administering any vaccines.

Approving Doctor's Signature: _____ Date: _____ Time: _____

"I have received the Vaccine Information Statement (VIS) about the prescribed vaccine/toxoid. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks associated with this vaccine/toxoid and I request that it be administered to the patient named below. I am authorized to make this request."

Signature of patient (Legal Representative if minor or incompetent adult)	Relationship to Patient	Date	Time	VIS Edition Date

Signature of Witness (Hospital Representative)	Date	Time

☐ **VACCINE/TOXOID DECLINED** Reason: _____

Signature of patient (Legal Representative if minor or incompetent adult)	Relationship to Patient	Date	Time

Signature of Witness (Hospital Representative)	Date	Time

VACCINE/TOXOID CONSENT FORM

St. Luke's Hospital
232 S. Woods Mill Road Chesterfield, MO 63017

Form No. SL-1456 CONSENTS TAB Rev. 07/2016

Patient Receiving Vaccine/Toxoid

This page is not part of the permanent Hospital Medical Record.

Please Print:

Last Name	First	Middle Initial	Date of Birth
			/ /

Street Address	City/State	Zip	Telephone Number
			( ) -

☐ Please send me information on upcoming wellness programs

I confirm that Medicare is my **primary** health insurance.

Medicare #:_____

Payment Method

_____Cash _____Check

_____Visa _____Mastercard _____Discover

Card #: _____

Exp. Date: _____ Amount: _____

Print Name: _____

Signature: _____