



CONS1001

VACCINE TO BE ADMINISTERED:

- | | | | |
|---|------------------------------------|---|---|
| <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Polio | <input type="checkbox"/> DT | <input type="checkbox"/> Pneumococcal |
| <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Rabies | <input type="checkbox"/> Td (greater than 10 years of age) | <input type="checkbox"/> PCV13 (generally for < 5 years of age) |
| <input type="checkbox"/> Hib (haemophilus
Influenzae type b) | <input type="checkbox"/> MMR | <input type="checkbox"/> Tetanus/Diphtheria/Acellular Pertussis | <input type="checkbox"/> PPSV23 |
| <input type="checkbox"/> Influenza | <input type="checkbox"/> Varicella | <input type="checkbox"/> DTaP | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Meningococcal ACWY | <input type="checkbox"/> HPV | <input type="checkbox"/> Tdap (greater than 10 years of age) | |
| <input type="checkbox"/> Herpes-Zoster | | | |

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: _____

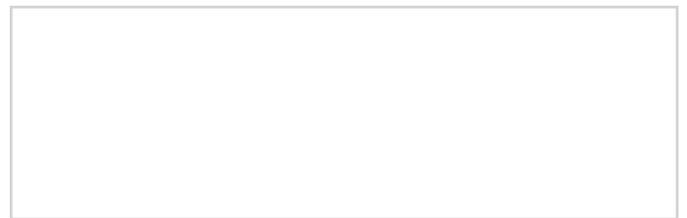
_____ Signature of patient (Legal Representative if minor or incompetent adult)	_____ Relationship to Patient	_____ Date	_____ Time
_____ Signature of Witness (Hospital Representative)		_____ Date	_____ Time

VACCINE/TOXOID CONSENT FORM

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St. Luke's Hospital

232 S. Woods Mill Road Chesterfield, MO 63017



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: _____