Internal Use Only:
MCIR: ☐Yes ☐No

VACCINE DOCUMENTATION AND CONSENT FORM

Patient Name: ____ DOB: ______________
First Middle Initial Last MM / DD / YY

I request, consent and authorize Nursing Practice Corporation, a Michigan non-profit corporation doing business as Campus Health Center, to administer the vaccine(s) selected below to me or to my minor child or ward listed as Patient on this Form.

✓		VIS Date	✓		VIS Date
	Hepatitis A			Polio (IPV)	
	Hepatitis B			Pneumococcal Polysaccharide (Pneumonia)	
	Human Papilloma Virus (HPV)			Tetanus, Diphtheria, & Pertussis (Tdap)	
	Influenza (Flu)			Typhoid	
	Measles, Mumps & Rubella (MMR)			Yellow Fever	
	Meningococcal (Meningitis/MCV4)			Varicella (Chicken Pox)	
	Meningitis B (Trumemba only)				

IMMUNIZATION SCREENING QUESTIONNAIRE

1. Have you ever had any allergic or adverse reaction to any vaccination? ___Yes ___No
   If Yes, please list:____
2. Are you currently taking any medications? ___Yes ___No
   If Yes, please list:____
3. Have you ever had an allergic reaction to any medication(s)? ___Yes ___No
   If Yes, please list:____
4. Have you ever had an allergic reaction to any food? ___Yes ___No
   If Yes, please list:____
5. Do you have an allergy to latex? ___Yes ___No
6. Have you ever had any other allergies or allergic reactions, in addition to those described above? ___Yes ___No
   If Yes, please list:____
7. Have you been sick or had a fever of 101° F or higher in the past 48 hours? ___Yes ___No
8. Have you had a seizure or other neurological problems? ___Yes ___No
9. Do you have (or there is a risk that you have) cancer, leukemia, HIV, AIDS, or any other immune system problem? ___Yes ___No
10. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments? ___Yes ___No
11. During the past twelve months, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? ___Yes ___No
12. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder? ___Yes ___No
13. Have you received any vaccinations in the past 4 weeks? ___Yes ___No

CONTINUE ONTO NEXT PAGE

VACCINE DOCUMENTATION AND CONSENT FORM *(Continued)*

14. *For women*: Are you pregnant or is there a chance that you could become pregnant during the next thirty (30) days? ___Yes ___No

15. *For women*: When was the first day of your last menstrual period? ____________________

Certification:

I understand that the practice of medicine is not an exact science, and no guarantees, promises or assurances have been made concerning the outcome of the above vaccination(s) or other medical procedures or treatment. I understand the potential and actual benefits, risks and hazards associated with receiving the selected vaccine(s), that I have the right to make decisions concerning my or Patient's health care, including the right to refuse vaccination(s), and that I am voluntarily receiving the selected vaccinations.

I have been given a copy of the Vaccine Information Statement(s) (VIS) for the vaccine(s) selected above. I certify that I have read or had this Vaccine Documentation and Consent Form (2 pages) and the VIS(s) read and/or explained to me, that I fully understand the information in the VIS(s) and the consents and authorizations given in this Form, that I have been given ample opportunity to ask questions about this Form, VIS(s) and the vaccine(s) selected above and that all questions have been answered to my satisfaction, and that I am the Patient listed in this Form or I am duly authorized by the Patient listed in this Form to provide the consents and authorizations described herein and to sign this Form.

I acknowledge and agree that the selected vaccination(s) is/are being administered by Nursing Practice Corporation, a Michigan non-profit corporation doing business as Campus Health Center, and not by or on behalf of Wayne State University (the "University") or any agent of the University, and that no health care provider relationship is being created between the University and the Patient as a result of receiving the selected vaccinations. I agree that I will not hold the University and/or its agents responsible for any liability, loss, charge, damage or expense caused or incurred by me as a result of my receiving or failure to receive any vaccinations.

References to "I", "me", "my", "you" and "your" in this Form refer to the person listed in this Form as the Patient, even though a next of kin, legal agent or guardian signs this Form on behalf of or for the Patient. If this Form is signed by next of kin, legal agent or guardian, such person represents and warrants that he or she has the necessary power and authority to execute this Form and to make decisions regarding the health care of the person listed in this Form as the Patient, and he or she agrees to indemnify, defend and hold Nursing Practice Corporation harmless in connection with that his or her breach of this representation and warranty. Nursing Practice Corporation may and shall treat, rely and enforce all statements made by Patient's next of kin, legal agent or guardian to the fullest extent permitted by law.

______________________________	______________________________	______________
Print Name	Signature of Patient or, if Patient is unable to sign, Signature of Next of Kin, Legal Agent/Guardian *and* Relationship to Patient	Date

If Patient is unable to sign, secure signature of Next of Kin or Legal Agent/Guardian and indicate reason why Patient is unable to sign:

- ☐ Minor
- ☐ Incompetent
- ☐ Disoriented
- ☐ Medically Unstable

OFFICE USE ONLY

Vaccine	Site	Location	Lot #	Vaccine	Site	Location	Lot #
1.	R L			4.	R L		
2.	R L			5.	R L		
3.	R L			6.	R L		

Admin Initials: __________ NP Initials: __________