City of Danbury Department of Health and Human Services
Travel Medicine and Immunization Center
155 Deer Hill Avenue • Danbury, CT 06810
Tel: (203) 797-4625 • Fax: (203) 796-1596

Vaccine Administration Record
Information Consent for Vaccination

Date: _____ **Vaccine Requested:** _____

SECTION A: DEMOGRAPHICS INFORMATION *(please print clearly)*

First Name: _____ Last Name: _____

Date of Birth: _____ / _____/ _____ Age: _____ Gender: ☐Female ☐Male

Address: _____ City: _____

State: _____ ZIP Code: _____

Phone: _____ E-mail: _____

PRIMARY CARE PHYSICIAN INFORMATION *(please print clearly)*

Doctor/Primary Care Provider Name: _____ Phone #: _____

Address: _____ City: _____ State: _____

SECTION B: INSURANCE INFORMATION *(please print clearly)*

Insurance Company: _____ Insurance Phone#: _____

Insurance Address: _____

Policy Number: _____ Group Number: _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____

SECTION C *The following questions will help us determine your eligibility to be vaccinated today.*		
All Vaccines		
1. Do you feel sick today?	Yes	No
2. Do you have any health conditions such as: heart disease, diabetes or asthma? If yes, please list: _____	Yes	No
3. Do you have allergies to latex, medications, food or vaccines? (Examples: eggs, bovine protein, gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal)?	Yes	No
4. Have you ever had a reaction after receiving an immunization, including fainting or feeling dizzy?	Yes	No
5. Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-Barre Syndrome (a condition that causes paralysis) or other nervous system problems?	Yes	No
6. **For women:** Are you pregnant or considering becoming pregnant in the next month?	Yes	No
Live vaccines (chickenpox, flu nasal spray, MMR II, oral typhoid, shingles, yellow fever) Only answer these questions if you are receiving any immunizations listed above.		
7. Have you received any vaccinations or skin tests in the past four weeks? If yes, please list: _____	Yes	No
8. Do you have a condition that may weaken your immune system (e.g. cancer, leukemia, lymphoma, HIV/AIDS, transplant)?	Yes	No
9. Are you currently on home infusions, weekly injections such as Humira (adalimumab), Remicade (infliximab) and Enbrel (etanercept), high-dose methotrexate, azathioprine or 6-mercaptopurine, antivirals, anticancer drugs or radiation treatments?	Yes	No

10. Are you currently taking high-dose steroid therapy (prednisone > 20mg/day or equivalent) for longer than 2 weeks?	Yes	No
11. Have you received a transfusion of blood, blood products or been given a medication called immune (gamma) globulin in the past year?	Yes	No
12. **(Yellow Fever Only)** Do you have a history of thymus disease (including myasthenia gravis, DiGeorge syndrome or thymoma), or had your thymus removed?	Yes	No
13. **(Oral Typhoid Only)** Are you currently taking any antibiotics or antimalarial medications?	Yes	No
14. **(MMR II Only)** Do you have a history of thrombocytopenia or thrombocytopenia purpura?	Yes	No
Flu nasal spray (FluMist Quadrivalent)		
15. Are you receiving aspirin therapy or aspirin-containing therapy? (18 years of age or younger only)	Yes	No
16. **(For FluMist Only)** Do you have a nasal condition serious enough to make breathing difficult, such as a very stuffy nose?	Yes	No

SECTION D

I have read or had explained to me the Vaccine Information Statement about the vaccine I have requested. I have had a chance to ask questions and I understand the benefits and risks of the vaccine. I request that the vaccine be given to me or to the person named above for whom I am authorized to make this request. I authorize the release of any medical or other information necessary to process an insurance claim. I have read and agree to the City of Danbury privacy policy. I understand that if my insurance does not fully cover the fee for this vaccination, that the City of Danbury may bill me for the balance of the fee.

Patient Signature: _____ Date: _____

Parent/Guardian Name: _____
(Parent or guardian, if minor)

FOR CLINIC USE ONLY

Complete BEFORE vaccine administration	
1. I have reviewed the **Patient Information** and **Screening Questions**.	Initial Here: _____
2. This is the **Vaccine Requested** by the patient.	Initial Here: _____
3. This vaccine is appropriate for this patient based on the **Age Guidelines** provided by federal and state policies.	Initial Here: _____
3a. Does this patient have a high-risk medical condition? If yes, please list medical condition(s): _____	☐ Yes ☐ No
4. The Vaccine NCD Matches the NDC on the bottom of this VAR form and the NDC on the patient leaflet	Initial Here: _____
5. I have verified the **Expiration Date** is greater than today's date and have entered the **Lot # and Expiration Date** in the field below.	Initial Here: _____

Complete DURING Patient Interaction	
1. I have asked the patient to confirm their **Name, DOB, and Requested Vaccine**. I have verified it matches the information on the VAR form.	Initial Here: _____
2. I have reviewed the **Screening Questions** with the patient.	Initial Here: _____
3. I have reviewed the **VIS** with the patient.	Initial Here: _____

Administration Date	VIS Date	VIS Given Date	Site of Administration	Immunizer Name	Immunizer Signature
Clinic Address:					

Vaccine Name	NDC	Manufacturer	Lot Number	Expiration Date	Dosage

Insert Vaccine Information Sticker Here:
(Vaccine Name, NDC, Manufacturer, Lot Number, Expiration Date, Dosage)