UNIVERSITY OF CALIFORNIA, SAN DIEGO • STUDENT HEALTH SERVICE, 0039

Patient Name	Phone Number Ok to leave message: ☐ Yes ☐ No

Current Meds: ☐ None _____

_____ LMP: _____

Med Allergy: ☐ NKDA _____

I would like the following Immunizations/Injections today:

☐ Hep A ☐ Flu (Influenza) ☐ Meningococcal ☐ Polio ☐ Tetanus/Diphtheria ☐ Typhoid ☐ Yellow Fever
☐ Hep B ☐ JE-VAX ☐ MMR ☐ Rabies ☐ Twinrix ☐ Varicella (Chickenpox) ☐ Other _____

Check Answers:

1. Do you feel sick today? ☐ Yes ☐ No
2. Do you have any current or ongoing health problems? ☐ Yes ☐ No If yes: what? _____
3. Based on the information sheet(s) given to you, have you found any reason you should not get the requested vaccine(s) today? ☐ Yes ☐ No If yes: what? _____
4. Have you ever had allergic reactions such as rash, hives, breathing problems? ☐ Yes ☐ No
5. Have you received any immunizations in the past 4 weeks? ☐ Yes ☐ No If yes: which ones? _____
6. During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin? ☐ Yes ☐ No
7. WOMEN ONLY: Are you pregnant, trying to become pregnant, or breast feeding? ☐ Yes ☐ No

I AGREE TO WAIT 20 MINUTES IN THE LOBBY FOLLOWING THIS VACCINE (30 MINUTES FOR JE-VAX). I have received and read the state/federal approved vaccine information statement and/or vaccine information sheet provided me by SHS. I understand the responsibilities and risks of taking this/these vaccine(s). Questions have been answered to my satisfaction. I request this/these vaccine(s) be given to me.

Signature Date

Comments: _____

_____

VIS Edition Date: Health Ed Provided ☐

Assessment IMMUNIZATIONS	*Provider Signature/Witness*	☐ MD ☐ NP ☐ RN	*Co-Sign*	*Date*

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