TREASURE COAST Primary Care

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MENNIGOCOCCAL VACCINE CONSENT

PATIENT AUTHORIZATION AND NOTICE

_____ _____

Patient Name Date of Birth

ADULT IMMUNIZATIONS – Screening Questionnaire (PLEASE READ)
The following questions will help us determine which vaccines you may be given today. If you answer **"YES"** to any question, it does not necessarily mean you should not be vaccinated, it just means additional questions must be asked. **If a question is not clear, please ask your healthcare provider to explain it.**

MENNIGOCOCCAL VACCINE QUESTIONS:

Are you sick today?	☐ YES	☐ NO
Do you have allergies to medications, foods, or vaccines? *Including gelatin or the antibiotic neomycin or any other component of the shingles vaccine.*	☐ YES	☐ NO
Have you ever had a serious reaction after receiving a vaccination?	☐ YES	☐ NO
Do you have a long-term health problem with heart disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorders?	☐ YES	☐ NO
Do you have cancer, leukemia, AIDS, or any other immune system problems?	☐ YES	☐ NO
Do you take cortisone, prednisone, other steroids, or anticancer drugs or have you had radiation treatments?	☐ YES	☐ NO
Have you had a seizure or other nervous system problem?	☐ YES	☐ NO
During the past year have you received a transfusion of blood or blood products?	☐ YES	☐ NO
For women: Are you pregnant or is there a chance you could become pregnant?	☐ YES	☐ NO
Have you received any vaccinations in the past 4 weeks?	☐ YES	☐ NO

I certify that I have been given the MENNIGOCCAL CDC Vaccine Information Statement before my injection. I have reviewed the information sheet; understand the possible side effects and I feel I have no contraindications to the administration of the vaccine.

_____ _____ _____

Signature of Recipient Date Witness

_____ _____ _____

Vaccine Manufacturer Lot Number Exp. Date

_____ Injection Site: ☐ Right Arm ☐ Left Arm

Signature of Nurse