KAISER PERMANENTE®

Name

Member I.D. Number

Date of Birth

Routine Childhood Vaccine Consent, 0-18 years

The vaccines we recommend for you or your child today are checked on this consent form. Please answer the questions with each recommended vaccine. If you answer "yes" to any of these questions or you don't know the answer, please don't sign this form before you talk to your doctor or nurse. Please read the Vaccine Information Statements (VIS) we gave you for the vaccines marked.

Insurance status (check one)	**American Indian/Alaskan Native for Vaccine for Children Program** (check one)
☐ Private insurance (ex. Kaiser Permanente) ☐ Uninsured (no health insurance) ☐ Underinsured (catastrophic insurance only) ☐ Medicaid (ex. Molina, DSHS)	☐ Yes ☐ No

	Yes	No
• Has the person getting any of the vaccines marked on this page had a serious (life-threatening) allergic reaction to a previous dose of the vaccine(s) or vaccine components such as latex?	☐	☐
• Is the person receiving these vaccines sick now, or have they been sick with a fever of 101 or greater?	☐	☐
• Has the person getting any of the vaccines marked on this page received another live vaccine in the last 4 weeks, such as MMR (Measles, Mumps, and Rubella), Shingles, or Varicella?	☐	☐

Recom-mended	Refused Today		Lot#	Yes	No
		Choose one tetanus-containing vaccine.	Lot#		
☐	☐	**DTaP** (Diphtheria, Tetanus & Pertussis), less than 7 years old			
		• Has this person ever had a serious reaction to DTaP shots (such as fever greater than 105º, seizures, ongoing crying for 3 hours or more, unusual high-pitched cry, or become pale, limp or less alert)?		☐	☐
☐	☐	**DT** (Diphtheria, Tetanus), less than 7 years old			
☐	☐	**Tdap** (Tetanus, Diphtheria & Pertussis), 10 years and older			
		• Is this person pregnant and fewer than 20 weeks along?		☐	☐
		• Has this person had Guillian Barré Syndrome (GBS)?		☐	☐
		• Does this person have a brain or nervous system disease that is getting worse?		☐	☐
☐	☐	**Td** (Tetanus, Diphtheria), 7 years and older			
		• Has this person had Guillian Barré Syndrome (GBS)?		☐	☐
		• Does this person have a brain or nervous system disease that is getting worse?		☐	☐
☐	☐	**Haemophilus Influenza B**	Lot#		
☐	☐	**Hepatitis A**	Lot#		
☐	☐	**Hepatitis B**	Lot#		
		• Is this person allergic to baker's yeast?		☐	☐
☐	☐	**Human Papillomavirus (HPV)**	Lot#		
		• Is this person pregnant?		☐	☐
		• Is this person allergic to yeast?		☐	☐
☐	☐	**Meningococcal Conjugate (MCV)**	Lot#		
		• Has this person had Guillian Barré Syndrome (GBS)?		☐	☐
☐	☐	**Measles, Mumps, and Rubella (MMR)**	Lot#		
		• Has this person had a serious allergic reaction to the drug neomycin?		☐	☐
		• Is this person less able to fight serious infections because of any disease (such as cancer, HIV infection), or treatment or drugs (such as steroids or radiation)? This means having a weakened immune system that makes it harder to fight off infection.		☐	☐
		• Is this person pregnant or likely to become pregnant within the next month?		☐	☐
		• Has this person been given a blood transfusion or immune globulin during the past several months?		☐	☐
		• Has this person ever had a low platelet count?		☐	☐
☐	☐	**Pneumococcal Conjugate (PCV)**	Lot#		
		• Has this person had a serious allergic reaction to a vaccine containing diphtheria toxoid (such as DTaP)?		☐	☐
☐	☐	**Pneumococcal Polysaccharide (PPV)**, high-risk 2-18 year olds	Lot#		
☐	☐	**Polio (IPV)**	Lot#		
		• Does this person have an allergy to the drugs neomycin, streptomycin or polymyxin B?		☐	☐

Continued on next page

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Recom-mended	Refused Today		Yes	No
☐	☐	**Rotavirus** Lot#		
		• Does this person have ongoing digestive problems or a history of intussusception?	☐	☐
		• Does this person have a weakened immune system for any reason?	☐	☐
☐	☐	**Chicken Pox (Varicella)** Lot#		
		• Has this person had a severe allergic reaction to the drug neomycin or to gelatin?	☐	☐
		• Is this person less able to fight serious infections because of any disease (such as cancer, HIV infection), or treatment or drugs (such as steroids or radiation)? This means having a weakened immune system that makes it harder to fight off infection.	☐	☐
		• Is this person pregnant or likely to become pregnant within the next month?	☐	☐
		• Has this person been given a blood transfusion or immune globulin during the past several months?	☐	☐
☐	☐	**Inactivated Influenza Vaccine** Lot#		
		• Has this person had an allergic reaction to eating eggs?	☐	☐
		• Has this person had Guillian Barré Syndrome (GBS)?	☐	☐
		• Is this person pregnant?	☐	☐

I read the Centers for Disease Control and Prevention's Vaccine Information Statements (VIS). I had a chance to discuss the nature, alternatives, benefit, and risks of the vaccine(s) marked above. I've had a chance to ask questions and they were answered to my satisfaction. I consent to the administration of the vaccine(s) marked above.

Signature of person authorized to give consent ______________________________ **Date** __________

For Staff use only:

Administered by (Signature & Title Required) ______________________________ Date __________

Document lot number from box next to each vaccine administered

FLU (INFLUENZA) VACCINE	MANUFACTURER
☐ FluZONE, (6-35 months), Quad *SYRINGE*	☐ Sanofi-Pasteur
☐ FluZONE, (3-18 yrs), Quad *VIAL*	
☐ FluARIX/FluZONE, (3-18 yrs), Quad *SYRINGE*	
☐ FluLaval, (36+ months), Quad *VIAL*	☐ GSK
☐ FluARIX, (36+ months), Quad *SYRINGE*	