GREATER NEW ORLEANS
IMMUNIZATION
NETWORK

LINKS #

PRINT

Today's Date:_____

Patient

First Name:

Middle Name:

Last Name:

Birth Date:

Sex: Age:

Race: ____ Asian or Pacific Islander
____ American Indian or Alaskan Native
____ Black, not of Hispanic origin
____ White, not of Hispanic origin
____ Hispanic

Physician:_____

Child qualifies for VFC program because he/she is:

Enrolled in Medicaid ❑

Does not have private insurance that covers vaccines ❑

American Indian or Alaskan Native ❑

Family and Address Information:

Guardian First Name:

Guardian Last Name:

Guardian Birth Date:

Relationship to patient:

Mother Maiden Name:

Address:

City/State:

Zip Code:

Phone:

Email Address:

Patient S.S. #

VACCINE ADMINISTRATION RECORD AND REGISTRY AUTHORIZATION

I agree to allow information about all vaccinations given to me or to the person for whom I am authorized to consent to be released to other medical care providers, schools, child care, or head start centers to avoid the administration of unnecessary vaccinations and to determine immunization status. I understand that this will remain in effect until canceled by me in writing. I hereby consent to the administration of the indicated immunizations. I acknowledge I have received and reviewed the CDC information on the risks and benefits of immunizations and that I have been allowed to ask questions and had my questions satisfactorily answered.

The Ronald McDonald Care Mobile is made possible by a grant for the Ronald McDonald House Charities, Inc. ("RMHC"), a non-profit, tax-exempt charitable corporation. RMHC has no responsibility or liability for the operation of the Ronald McDonald Care Mobile or any of the medical or dental activities conducted herein.

IMPORTANT
Answer questions and sign on back

	Yes	No	Don't Know
1. Does the child have any health problems, now or in the past? If yes, please list: _____	☐	☐	☐
2. Does the child have allergies to vaccines, medications, Thimerosal, Gentamicin, gelatin, baker's yeast, eggs or egg products? If yes, please list: _____	☐	☐	☐
3. Has the child had a serious reaction to a vaccine in the past? If yes, please list: _____	☐	☐	☐
4. Does the child have cancer, leukemia, AIDS, or any other immune system disorder? If yes, please list: _____	☐	☐	☐
5. Has the child taken cortisone, prednisone or other steroids; anticancer drugs, or had radiation treatment in the past 3 months? If yes, please list: _____	☐	☐	☐
6. Has the child received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin in the past year? If yes, please list: _____	☐	☐	☐
7. Is the child/teen pregnant or at risk of becoming pregnant in the next month? If yes, please list: _____	☐	☐	☐
8. Has the child had chickenpox?	☐	☐	☐
9. Has the child received the chickenpox vaccine?	☐	☐	☐
10. Has the child received any vaccinations in the past 4 weeks? If yes, please list: _____	☐	☐	☐
11. Does your child have a prior history of Guillain-Barre Syndrome? If yes, please list: _____	☐	☐	☐
12. List any current medications: _____			
13. **Are there any immunizations that you would NOT like your child to receive? If yes, please list:** _____	☐	☐	☐

Signature of Parent/Guardian or adult vaccine recipient

➡ _____ **Date:** _____

DTaP / Td / TDaP	**IPV**	**MMR**	**HIB**	**KINRIX**
Site of Injection: LA RA LT RT	Site of Injection: LA RA LT RT	Site of Injection: LA RA LT RT	Site of Injection: LA RA LT RT	Site of Injection: LA RA LT RT
Dose 1 2 3 4 5	Dose 1 2 3 4 5	Dose 1 2 3 4 5	Dose 1 2 3 4 5	Dose 1 2 3 4 5

HBV	**HAV**	**VARICELLA**	**PENTACEL**	**RV**
Site of Injection: LA RA LT RT	Site of Injection: LA RA LT RT	Site of Injection: LA RA LT RT	Site of Injection: LA RA LT RT	Oral
Dose 1 2 3 4 5	Dose 1 2 3 4 5	Dose 1 2 3 4 5	Dose 1 2 3 4 5	Dose 1 2 3 4 5

HPV	**PCV-13**	**PEDIARIX**	**MCV4**	
Site of Injection: LA RA LT RT	Site of Injection: LA RA LT RT	Site of Injection: LA RA LT RT	Site of Injection: LA RA LT RT	Site of Injection: LA RA LT RT
Dose 1 2 3 4 5	Dose 1 2 3 4 5	Dose 1 2 3 4 5	Dose 1 2 3 4 5	Dose 1 2 3 4 5

FOR CLINIC USE ONLY

I certify that the Vaccine Information Statement(s) for vaccine(s) administered above were presented to the person or parent/guardian named above, at the clinic and on the date shown here.

Clinic: _____ **Date:** _____ **Signature and title of the Vaccine Administrator** _____