MHSF Health Centers

Chalmette High School Based Health Center

Office: (504) 333-6988

Nunez Community College Health Center

Office: (504) 278-6318

IMMUNIZATION ADMINISTRATION HISTORY and CONSENT

Date:_____

Patient Name:_____ DOB: _____ ID#_____

Please select insurance type: ☐ **Private Insurance** ☐ **Medicaid** ☐ **No Insurance**

Vaccines:

☐ COVID-19 _____
☐ Hep A (Hepatitis A) _____
☐ Hep B (Hepatitis B) _____
☐ Influenza (Flu) _____
☐ HPV (Human papillomavirus) _____
☐ Meningococcal ACWY _____
☐ Meningococcal B _____
☐ MMR (Measles, mumps, rubella) _____
☐ Other _____
☐ Pneumovax _____
☐ Polio _____
☐ Shingles _____
☐ Tdap /Dtap _____
☐ Varicella (chickenpox) _____

Please check "yes" or "no" below (for vaccine recipient):	**Yes**	**No**
1. Allergies to Medications, foods, or vaccines? If yes, Allergy to:_____ Reaction:_____	○	○
2. Serious reaction to vaccines in the past? If yes, Vaccine:_____ Reaction:_____	○	○
3. Seizure disorder?	○	○
4. Cancer, Leukemia, HIV/AIDS or any other immune problem?	○	○
5. History of cortisone, prednisone, other steroids use or anticancer/chemo medications/radiation?	○	○
6. History of transfusion of blood or blood products or immune (gamma) globulin	○	○
7. History of Guillain Barre-Syndrome?	○	○
8. Received a vaccine in the last 4 weeks?	○	○
Females Only:		
9. Pregnant or at risk for becoming pregnant in the next month?	○	○
10. Date of last menstrual cycle?		

I certify that I am the patient and at least 18 years old or a legal guardian of a minor patient. I understand that this will remain in effect until cancelled by me in writing. I hereby consent to the administration of the indicated vaccines. I acknowledge I have received and reviewed the CDC Vaccine Information Statements risks and benefits of immunizations. I have been allowed to ask questions and have had my questions satisfactorily answered.

_____ **Date: _____**

Electronic or Written Signature of Patient/Parent or Guardian (if minor)

Print Guardian Name: _____ Phone #:_____

OFFICE USE ONLY: