# INFORMATION ABOUT THE ADULT RECEIVING THE VACCINE

| FIRST NAME | MI | LAST NAME | MAIDEN NAME |
|---|---|---|---|
| | | | |

| DOB *(mm/dd/yy)* | AGE | SEX | WEIGHT |
|---|---|---|---|
| | YRS | ◯ M ◯ F | LBS |

| ADDRESS |
|---|
| |

| CITY | STATE | ZIP |
|---|---|---|
| | | |

| PRIMARY PHONE *(###) ###-####* |
|---|
| |

| EMAIL |
|---|
| |

## HEALTH INSURANCE STATUS *(Required Information - however, we do not bill)*

◯ UNINSURED ◯ UNDER-INSURED ◯ MEDICAID ◯ PRIVATE INSURANCE

| SCREENING QUESTIONS | YES | NO | DON'T KNOW |
|---|---|---|---|
| 1. Are you sick today? *(i.e., fever above 101°F)* | ◯ | ◯ | ◯ |
| 2. Have you ever had an allergic or serious reaction *(i.e., anaphylactic reaction, hives, swelling, respiratory distress, wheezing)* to any of the *items below* that required treatment with epinephrine or EpiPen® or caused you to go to the hospital? ● Polyethylene glycol *(PEG),* which is found in some medications, such as laxatives and preparations for colonoscopy procedures ● Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids ● Medications ● Food ● Latex | ◯ | ◯ | ◯ |
| 3. Do you have a long-term health problem with heart *(including pericarditis and/or myocarditis)*, lung, kidney, or metabolic disease *(e.g., diabetes)*, asthma, a blood disorder *(including taking blood thinners, history of heparin induced thrombocytopenia (HIT), etc.)*, no spleen, complement component deficiency, Multisystem Inflammatory Syndrome *(MIS-C or MIS-A)*, a cochlear implant, or a spinal fluid leak? | ◯ | ◯ | ◯ |
| ● Are you on long-term aspirin therapy? | ◯ | ◯ | ◯ |
| 4. Do you or a close family member have cancer, leukemia, HIV, or any other immune system problem? | ◯ | ◯ | ◯ |
| 5. In the past 3 months, have you taken medications that affect the immune system, such as prednisone, other steroids, or anti-cancer drugs, drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis, or have you had radiation treatments? | ◯ | ◯ | ◯ |
| 6. During the past year, have you received a transfusion of blood or blood products, or been given immune *(gamma)* globulin, monoclonal antibodies, convalescent serum, or an antiviral drug? | ◯ | ◯ | ◯ |
| 7. Have you received any vaccinations in the past 4 weeks? If so, which one? | ◯ | ◯ | ◯ |
| 8. Have you received dermal fillers? | ◯ | ◯ | ◯ |
| 9. ***For FEMALES:*** Are you pregnant or is there a chance you could become pregnant during the next month? | ◯ | ◯ | ◯ |
| ● Are you breastfeeding? | ◯ | ◯ | ◯ |
| 10. Do you have any physical, developmental, or behavioral limitations? If yes, what additional support is needed? | ◯ | ◯ | ◯ |

| MEDICAL PROFESSIONAL OR SCREENER ONLY INITIALS _____ | AVAILABLE IMMUNIZATION RECORD IN IIS? | YES | NO |
|---|---|---|---|
| | REQUIRED VIS Offered *(please circle)* | YES | NO |

## CONSENT

I have read or have had explained to me the above information and received a copy of the Vaccine Information Statement and understand Spokane Regional Health District's (SRHD) Privacy Policy. I have had a chance to ask questions, which were answered to my satisfaction. I consent to inclusion of this data in the Washington State Immunization Information (IIS) Registry. I believe I understand the benefits and risks of the vaccines checked on page two and request that the vaccine be given to me or the person named for whom I am authorized to make this request. Also, by signing this consent, I give permission for myself (and any of my children, if applicable) to be filmed or photographed during the immunization clinic today.

SIGNATURE _____ DATE _____

# ADULT VACCINES

| VACCINES RECOMMENDED | | | | |
|---|---|---|---|---|
| ☐ HEP A | ☐ HEP B | ☐ HEP A/B *(Twinrix)* | ☐ HPV9 | ☐ INFLUENZA *(Flu)* |
| ☐ MMR | ☐ PCV13 | ☐ PPSV23 | ☐ SHINGLES | ☐ TDAP |
| ☐ COVID-19<br>☐ J & J ☐ Moderna 0.5mL ☐ Moderna 0.25mL ☐ Pfizer ☐ Novavax | | | | |

| VACCINE | VIS | MANUFACTURER | LOT # | EXP DATE | INJECTION SITE | ROUTE |
|---|---|---|---|---|---|---|
| | | *(PLEASE WRITE INFORMATION BELOW CLEARLY)* | | | | |
| HEP A | 10.15.21 | | | | ☐ LA ☐ RA | IM |
| HEP B | 10.15.21 | | | | ☐ LA ☐ RA | IM |
| HEP A/B *(Twinrix)* | 10.15.21 (HEP A)<br>10.15.21 (HEP B) | | | | ☐ LA ☐ RA | IM |
| HPV9 | 08.06.21 | | | | ☐ LA ☐ RA | IM |
| INFLUENZA *(FLU)* | 08.06.21 | | | | ☐ LA ☐ RA | IM |
| MMR | 08.06.21 | | | | ☐ LA ☐ RA | SC |
| PCV13 | 02.04.22 | | | | ☐ LA ☐ RA | IM |
| PPSV23 | 10.30.19 | | | | ☐ LA ☐ RA | IM |
| SHINGLES | 02.04.22 | | | | ☐ LA ☐ RA | IM |
| TDAP | 08.06.21 | | | | ☐ LA ☐ RA | IM |
| COVID-19 | | J & J | | | ☐ LA ☐ RA | IM |
| COVID-19 | | MODERNA **0.5mL** | | | ☐ LA ☐ RA | IM |
| COVID-19 | | MODERNA **0.25mL** | | | ☐ LA ☐ RA | IM |
| COVID-19 | | PFIZER | | | ☐ LA ☐ RA | IM |
| COVID-19 | | NOVAVAX | 4302MF023 | 02.28.23 | ☐ LA ☐ RA | IM |

VACCINATOR NAME / INITIALS
*AND* CREDENTIALS _____

***Please PRINT your information clearly***