

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. #

<input type="text"/>	<input type="text"/>	<input type="text"/>
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**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:** \_\_\_\_\_

<b>DTaP / Td / TDaP</b> Site of Injection: LA RA LT RT Dose 1 2 3 4 5	<b>IPV</b> Site of Injection: LA RA LT RT Dose 1 2 3 4 5	<b>MMR</b> Site of Injection: LA RA LT RT Dose 1 2 3 4 5	<b>HIB</b> Site of Injection: LA RA LT RT Dose 1 2 3 4 5	<b>KINRIX</b> Site of Injection: LA RA LT RT Dose 1 2 3 4 5
<b>HBV</b> Site of Injection: LA RA LT RT Dose 1 2 3 4 5	<b>HAV</b> Site of Injection: LA RA LT RT Dose 1 2 3 4 5	<b>VARICELLA</b> Site of Injection: LA RA LT RT Dose 1 2 3 4 5	<b>PENTACEL</b> Site of Injection: LA RA LT RT Dose 1 2 3 4 5	<b>RV</b> Oral Dose 1 2 3 4 5
<b>HPV</b> Site of Injection: LA RA LT RT Dose 1 2 3 4 5	<b>PCV-13</b> Site of Injection: LA RA LT RT Dose 1 2 3 4 5	<b>PEDIARIX</b> Site of Injection: LA RA LT RT Dose 1 2 3 4 5	<b>MCV4</b> Site of Injection: LA RA LT RT Dose 1 2 3 4 5	Site of Injection: LA RA LT RT 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.

**Signature and title of the  
Vaccine Administrator** \_\_\_\_\_

**Clinic:** \_\_\_\_\_ **Date:** \_\_\_\_\_