Hamilton County Public Health Vaccine Administration Record

Child's Last Name________________________ First Name___________________

Birth Date__________ Current Age_____ Gender: (circle) Male/Female

Address_______________________ City__________________Phone__________

Please Mark One: Insured_______ Not Insured______Medicaid_______

Please answer the following questions?

1. Does the child have any food or medication allergies? Yes____ No____
   If Yes, what are they?_________________________
2. Has the child had a serious reaction to a vaccine in the past? Yes___ No____
   If Yes, what vaccine and what occurred?___________________________
3. Does the child have cancer or is the child on medications that lower the body's resistance to infection? Yes___ No___

I have read and understand the appropriate Vaccine Information Statement. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the vaccine and ask that the vaccine be given to the person's name for which I am authorized to make this request. I accept responsibility for seeking medical attention for any problems with this vaccination.

Signature of Parent/Guardian___________________________________Date_______________

-- -office use only--

Vaccine	Date	Lot #
Tdap		
VIS		
1/24/2012		