Western Washington University Student Health Center

Questionnaire and Consent for Immunizations

Please Print

NAME: ____

Student Number: ____________________ Birthdate: ______________

	Please answer the following questions by checking the boxes. If the question is not clear, please ask the nurse to explain it.	Yes	No
1	Are you acutely ill today? (mild cold symptoms are ok)		
2	Do you have allergies to medications, food, latex or any vaccines?		
3	Have you had a serious reaction after receiving a vaccination?		
4	Have you had a seizure, brain or other nervous system problem?		
5	Do you have cancer, leukemia, AIDS, or any other immune system problem?		
6	Do you take cortisone, prednisone, other steroids, anticancer drugs, or have you had radiation treatments?		
7	Are you currently taking antibiotics or anti-viral medication?		
8	Have you received a transfusion of blood or blood products, or a medicine called immune (gamma) globulin in the past year?		
9	For Women: Are you pregnant or is there a chance you could become pregnant during the next month?		
10	Have you received any vaccinations in the past 4 weeks?		
11	Do you have a long-term health problem, i.e. heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g. diabetes), or other blood disorder?		

Please circle below the vaccines you are requesting:

Hepatitis A / Hepatitis B / Twinrix / HPV / Influenza / Japanese Encephalitis / Menactra / Menveo / Men-B / MMR / Polio / PPSV 23 / PCV13 / Oral Typhoid / Rabies / Td / Tdap / Typhim Vi / Varicella

I have been given a copy and have read, or had explained to me, the information in the Vaccine Information Statement(s). I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s).

I agree to the above vaccine(s). (Please sign below.)

X ____ Date: _________________

Signature of person requesting the vaccine(s).(patient or guardian if patient is a minor)