AGE:

THE CITY UNIVERSITY OF NEW YORK
IMMUNIZATION CONSENT FORM FOR HEPATITIS B VACCINATIONS

COLLEGE	TELEPHONE#	EMERGENCY CONTACT#		
LAST NAME		FIRST		MIDDLE
□ MALE □ FEMALE □ MTF □ FTM	MOTHER'S MAIDEN NAME	DATE OF BIRTH MONTH	DAY	YEAR
ADDRESS	APT.	CITY	STATE	ZIP

SCREEN A

ALL INFORMATION PROVIDED WILL BE KEPT CONFIDENTIAL

PLEASE CHECK THE APPROPRIATE BOX (ES) BELOW

1. Do you have health insurance? □ YES □ NO
2. If yes, who is your health insurance carrier?

□ Sponsored by Parent/Guardian
□ HealthCare Exchange Pla
□ Underinsured
□ Private (ex. Aetna, Blue Cross, HIP)
□ Child Health Plus
□ Medicaid
□ Uninsured
□ Other: (specify) ___________________

Covered by:
□ Spouse
□ Domestic Partner
□ Employee

SCREEN B

CIRCLE ONE

1. Are you feeling sick with anything other than a cold today?	YES	NO
2. Have you ever had an allergic reaction to baker's yeast?	YES	NO
3. Do you have allergies to medications, latex or any vaccine?	YES	NO

a. If so, please list: ____

b. What type of allergic reaction did you have to the meds, latex or vaccine? ___________________________

FEMALES ONLY

4. Are you pregnant now? YES NO

5. Date of last menstrual period? ______________________________

Interviewed by: ____

CONSENT

IF THIS IS YOUR FIRST IMMUNIZATION YOU MUST WAIT 30 DAYS BEFORE HAVING YOUR SECOND IMMUNIZATION AND AT LEAST 6 MONTHS FOR YOUR 3rd IMMUNIZATION

I have read the information contained in the Vaccine Information Statement about the disease(s) and the vaccine(s). I have had a chance to ask questions which, if any, were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) indicated below be given to me or to the person named for whom I am authorized as parent, guardian, or long term custodian to make this request.

Yo he leido la Declaracion de Vacunas acerca de la(s) enfermedad(es) y la(s) vacuna(s). He tenido la oportunidad de hacer preguntas las cuales, si hubo algunas, fueron contestadas a mi satisfaccion. Creo que comprendo los beneficios y riesgos de la(s) vacuna(s) y pido que me den la(s) vacuna(s) indicada(s) mas abajo a mi o a la persona nombrada por quien estoy authorizado(a) como padre, guardian, o cuidador por largo tiemp[o para hacer esta peticion.

PATIENT/PARENT SIGNATURE
FIRMA DEL PACIENTE/PADRE ______________________________

DATE
FECHA _______________

OFFICE USE ONLY

Vaccine	Dose #	Dosage	V. I.S.	Injection Site	Manufacturer I.D.	Lot #	Expiration Date
Hepatitis B				LUA/RUA			

Innoculator Signature: **Date:**

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