Vaccine Administration Record

Patient Name _____

Unit _____

Birth date _____

*Signature of Vaccine Administrator

_____

_____

_____

Use reverse side if more signatures are needed

Please provide us with a copy of your child's immunization records

While your child is residing at Orchard Place, we will review these records and determine if he/she is due for any boosters at admission or during his/her stay.

Please indicate your permission for boosters to be administered to your child by our medical staff by signing on each line marked with an "X". Boosters will be administered only when they are due and parent/guardian has signed below. Depending on time of admission and length of stay your child may receive two flu shots during his/her course of treatment at Orchard Place.

If you prefer that your child does not receive immunization boosters and/or a seasonal flu vaccination, please write "Declined" on the form and sign.

"I have read, or have had explained to me information about the diseases and the vaccines listed below. I understand the benefits and risks of the vaccines cited, and ask that the vaccine(s) listed below be given to my child or to the person named above for whom I am authorized to make this request. I will not hold Orchard Place or associated health personnel responsible for any side effects that may accompany these immunizations. I acknowledge that my child has never had a serious reaction to a previous flu vaccine and that he/she is not allergic to any of the following:

Thimersal (a preservative found in many vaccines)	Yes	No
Gentamincin (an antibiotic)	Yes	No
Eggs	Yes	No

_____ _____

Parent Signature/Date Witness/Date

	Date Given	Vaccine Manufacturer	Vaccine Lot Number	Site Given	Administrator Initials of Vaccine	Signature of Parent or Guardian
Hep B 1						
Hep B 2						
Hep B 3						
Hep A 1						
Hep A 2						
HPV 1						
HPV 2						
HPV 3						
Tdap						
Menactra1						
Menactra 2						
Seasonal Flu						