

## Immunization Request

Sea Mar Clinic 9710 State Ave. Marysville, WA 98270

Snohomish Health District 3020 Rucker Ave Suite 108 Everett, WA 98201

### Information about person to receive vaccine (please print)

<b>Last Name</b>		<b>First Name</b>		<b>MI</b>	
<b>Birth date</b>	<b>Age</b>	<b>Sex (circle one)</b>  M      F	<b>Phone</b>		
<b>Address</b>		<b>City</b>	<b>State</b>	<b>Zip</b>	

**PLEASE READ THE LIST BELOW AND INDICATE YES OR NO FOR THE PERSON RECEIVING VACCINE TODAY**

	YES	NO
Has this person ever had a severe reaction to any vaccine which required medical care?	_____	_____
Is this person allergic to eggs or gelatin?	_____	_____
Does this person have a fever, diarrhea or vomiting today?	_____	_____
Has this person had Guillain-Barre' syndrome, a condition which causes paralysis?	_____	_____
If this person is pregnant, are they at least twenty weeks along?	_____	_____
Do you work at a licensed child care?	_____	_____
How did you hear about the free Tdap clinic? _____		

INFO. REC'D.	# IN SERIES	Tdap 01/24/12	Man. Sanofi	Lot # C4034AA*	Exp. Date 06/08/14	Site/Route/Dose LD RD /IM / 0.5cc	Provider Signature
INFO. REC'D.	# IN SERIES	Influenza 07/29/11	Man. Sanofi	Lot # UH506AB*	Exp. Date 06/30/12	Site/Route/Dose LD RD/IM/0.5cc	Provider Signature

I have read or have had explained to me the information contained in the **VACCINE INFORMATION STATEMENT(S)** about the disease(s) and the vaccine(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) and request that the vaccine(s) be given to me or to the person named above for whom I am authorized to make this request. I have been given the **Notice of Privacy Practices**. I understand that my records will be entered into the Child Profile database.

\_\_\_\_\_  
SIGNATURE OF PERSON TO RECEIVE VACCINE OR PERSON AUTHORIZED TO MAKE REQUEST

\_\_\_\_\_  
RELATIONSHIP

\_\_\_\_\_  
DATE

Please mark the immunizations to be received.    Tdap         Flu