

# Auburn Montgomery Student Health Center

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## Consent for Yellow Fever Vaccine

I hereby give my consent to be vaccinated against Yellow Fever. I have been given information and an opportunity to ask questions about the vaccine and the risks involved. All my questions have been answered to my satisfaction. I have been informed that persons are at an increased risk for a reaction if they are:

- 1) Allergic to a component to the vaccine;
- 2) Over age 60;
- 3) Have thymus disorder or disease; or
- 4) Are immunocompromised (by HIV, cancer or medications, etc.).

Further, pregnant and breast-feeding women should not take the vaccine without consulting their OB-GYN or pediatrician. I understand that I may consult with my private physician about the vaccine should I desire to do so. I understand that as with all medical treatments, there is no guarantee that I will not experience an adverse effect.

Christopher Adams.

Printed Name (Individual to receive vaccine)



(Signature) Individual to receive vaccine)

7-15-16

Date

\_\_\_\_\_  
Witness (Licensed personnel)

\_\_\_\_\_  
Date

Patient name: Chris Adams

Date of birth: 10/9/85  
(mo.) (day) (yr.)

# Screening Checklist for Contraindications to Vaccines for Adults

**For patients:** The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

|                                                                                                                                                                                               | Yes                                 | No                                  | Don't Know               |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|-------------------------------------|--------------------------|
| 1. Are you sick today?                                                                                                                                                                        | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have allergies to medications, food, a vaccine component, or latex? <i>penicillin</i>                                                                                               | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> |
| 3. Have you ever had a serious reaction after receiving a vaccination?                                                                                                                        | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?                      | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?                                                                                                                | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 6. In the past 3 months, have you taken medications that weaken your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments? | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you had a seizure or a brain or other nervous system problem?                                                                                                                         | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?                                              | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?                                                                                          | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> |
| 10. Have you received any vaccinations in the past 4 weeks?                                                                                                                                   | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |

Form completed by: Chris Adams  
Form reviewed by: [Signature]

Date: 7-15-16  
Date: 7/15/16

Did you bring your immunization record card with you? yes ☐ no ☒  
It is important for you to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.

Patient name:

Christopher Adams

Date of birth:

10/19/85  
(mo.) (day) (yr.)

# Screening Checklist for Contraindications to Vaccines for Adults

**For patients:** The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

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| 2. Do you have allergies to medications, food, a vaccine component, or latex?<br><i>penicillin</i>                                                                                            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> |
| 3. Have you ever had a serious reaction after receiving a vaccination?                                                                                                                        | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?                      | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?                                                                                                                | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
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Form completed by:

Christopher Adams

Date:

8-16-16

Form reviewed by:

[Signature]

Date:

8/16/16

Did you bring your immunization record card with you?

yes ☐ no ☒

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