

Auburn Montgomery Student Health Center

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.

Faye Ayeni
Printed Name (Individual to receive vaccine)

[Signature]
(Signature) Individual to receive vaccine)

11/29/16
Date

[Signature]
Witness (Licensed personnel)

11/29/16
Date

Nigeria 12/12/16

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME

Faye Ayeni

DATE OF BIRTH

07 / 25 / 82
month / day / year

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?	☐	☒	☐
2. Do you have allergies to medications, food, a vaccine component, or latex?	☐	☒	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☒	☐
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?	☐	☒	☐
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☒	☐
6. In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?	☐	☒	☐
7. Have you had a seizure or a brain or other nervous system problem?	☐	☒	☐
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?	☐	☒	☐
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?	☐	☐	☒

? flu vaccine

FORM COMPLETED BY

Faye Ayeni

DATE

11/29/16

FORM REVIEWED BY

[Signature]

DATE

11/29/16

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 health care provider records all your vaccinations on it.