

Immunization Consent Form

Print Name: _____ DOB: _____

UC Campus: _____ School/Year _____ Anthem ID# _____

Did you waive Student Health Insurance Plan this quarter? (circle) Yes / No
Must pay in full if waived or not covered by UC SHIP - Anthem Blue Cross

Reason for Seeking Immunization (check all that apply):

- New Student Entry Requirements Travel Other: _____
 Laboratory Pre-Exposure Prophylaxis Routine/Annual
 Pre-Employment/Internship Requirement Post-Exposure Prophylaxis

Are you pregnant or are you planning to get pregnant?	Y	N	Do you have allergies to any vaccines?	Y	N
Are you allergic to eggs?	Y	N	Are you allergic to bees/wasps?	Y	N
Are you allergic to gelatin?	Y	N	Are you allergic to any medications?	Y	N
Are you taking steroid medications?	Y	N	Do you have cancer?	Y	N
Do you have an immune system problem?	Y	N	Do you have a seizure, brain, or nerve problem?	Y	N
Have you ever fainted?	Y	N	Do you have asthma?	Y	N
Have you received blood products or Ig in the last year?	Y	N	Have you ever had a bad reaction to a vaccine?	Y	N

- Students without UC SHIP (Anthem Blue Cross) are responsible for payment in full. Your signature below constitutes agreement to pay for such services**
- I am advised to remain in SHCS for 30 minutes after live virus vaccines (MMR, Varicella and Yellow Fever) and 20 minutes for all new vaccines, to be monitored for adverse reactions. 30 minutes wait time is advised for both JE vaccines #1 and #2.
- I have read and understand the Vaccine Information Sheet regarding the vaccine(s) I will be receiving and have been given the opportunity to discuss my concerns regarding the vaccine(s). I give my consent to UCSF Student Health Service to administer the vaccine(s) checked below:

Signature: _____ Date: _____

Provider's Order: Administer one dose of each required vaccine according to dose noted below and consistent with current manufacturer's instructions. Standing Order by: Chaitail Mukherjee, MD, Medical Director, Student Health and Counseling Services

PRICE	√	VACCINE	DOSE	MAKER	LOT NO.	EXPIRES	GIVEN BY
		Hep A #1 #2	0.5ml IM R L deltoid				
		Hep B #1 #2 #3	1ml IM R L deltoid				
		HPV #1 #2 #3	0.5ml IM R L deltoid				
		Influenza	0.5ml IM R L deltoid				
		MMR #1 #2	0.5ml SQ R L arm				
		Varicella #1 #2	0.5ml SQ R L arm				
		TDAP	0.5ml IM R L deltoid				
		Pneumococcal	0.5ml IM R L deltoid				
		Polio	0.5ml IM R L deltoid				
		Meningococcal	0.5ml IM R L deltoid				
		Rabies #1 #2 #3	1ml IM R L deltoid				
		Typhoid Injectable	0.5ml IM R L deltoid				
		Typhoid Oral	4 capsules PO				
		J. E. #1 #2	0.5ml IM R L deltoid				
		Yellow Fever	0.5ml SQ R L arm				

ADMINISTRATIVE USE - STUDENT HEALTH STAFF ONLY: PAID: _____ CHARGE / CASH INITIAL _____