MENINGOCOCCAL VACCINE CONSENT FORM

Information about person to be vaccinated (Please print)

Last Name:________________________________

First Name:______________________________ Age:_____

Date of Birth:________________ Sex: M F

Address: ____

City:_________________________________ Zip:_________

Parent/Guardian:_________________________________

Phone number: _________________________________

Two doses are recommended for adolescents 11-18 yrs.

- ★ 1st dose at age 11-12, with a booster dose at age 16
- ★ If the 1st dose is given between age 13-15, a booster dose should be given between 16-18
- ★ If 1st dose is given after 16th birthday, booster not needed

The Immunization Registry Information System (IRIS) is an automated system to document vaccinations given in Iowa. IRIS will give parents access to their child's immunization record from any participating Iowa provider. IRIS allows providers to send reminder notices regarding needed immunizations. Health care providers, health care facilities, federal or state agencies, welfare agencies, school or family day care facilities may have access to this information. Immunization records remain confidential, and any person who fails to protect the confidentiality of this information is guilty of a Class 1 misdemeanor. If you choose **NOT** to have your/your child's immunization record shared with other providers you may request a refusal form.

For a child being vaccinated - check any that apply **(Check here if none apply)**

____ Enrolled in Medicaid

____ Does not have health insurance

____ American Indian or Alaskan Native

____ Health insurance that DOES NOT pay for vaccines

Please answer the following questions for the person to be vaccinated:

	Yes	No	Don't Know
1) Is the child sick today?	____	____	____
2) Does the child have allergies to medication, food, a vaccine component, or latex?	____	____	____
3) Has the child ever had a serious reaction to a vaccine in the past?	____	____	____
4) Has the child received a previous dose of meningococcal vaccine?	____	____	____

I have been provided a copy of and have read or have had explained to me the information about meningococcal vaccine and have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request.

Signature ________________________________ **Date** ______________

(Parent or guardian if minor)

for office use only

	Type	Date/Time	Vaccine Manufacturer	Vaccine Lot number	Route	Site (Circle)	Date of VIS Publication	Full signature of person administering vaccine
Meningococcal	MenACY		Sanofi Pasteur (Menactra)		IM	L R Deltoid Thigh	3/31/16	