

WOMEN'S HEALTH PARTNERS, LLC

DIPLOMATES OF THE AMERICAN BOARD OF OBSTETRICS & GYNECOLOGY

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VACCINE CONSENT FORM AND ADMINISTRATION RECORD

Please check the box for the appropriate answer to the following questions: YES NO

Are you currently sick with anything other than a mild cold? YES NO

Have you ever had a serious allergic reaction to gelatin, neomycin, baker's yeast or any previous vaccine? YES NO

Do you have a disease that affects the immune system or are you taking cortisone, prednisone, other steroids, anti-cancer drugs or x-ray/radiation treatments for cancer? YES NO

Have you recently received blood, plasma or immune globulin? YES NO

Are you currently pregnant or breast feeding or planning to become pregnant in the next month? YES NO

I have been given a copy and have read or have had explained to me, the information in the Vaccine Information Statement(s) for the vaccine(s) checked below. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) requested and ask that the vaccine(s) checked below be given to me.

Hepatitis A Hepatitis B Hepatitis A/B (Twinrix) Gardasil (HPV) Pneumovax

Tetanus/Diphtheria (Td) Tetanus/Diphtheria/Pertussis (Tdap) Shingrix (Shingles)

Prevnar 13 RhoGAM Other: _____

Signature: _____

Print Name: _____

Date of Birth: _____ Patient ID: _____