Crawford County Mass Vaccination Clinic
Patient Record

PATIENT INFORMATION

Last Name:_____ First Name:_____ Middle Initial: ____
Address: _____
City: _____ State:_____ Zip:_____
Birth Date: _____SSAN#_____
Sex (Circle) **Male** **Female** Phone: _____

PHYSICIAN INFORMATION

Physician Name: _____ Phone_____
Address: _____ Fax_____
City: _____ State: _____ Zip_____

PARENT INFORMATION (IF A MINOR)

Mother s Name: _____ Phone_____
Address:_____ SSAN#_____
City: _____ State:_____ Zip_____

Father s Name: _____ Phone_____
Address:_____ SSAN#_____
City: _____ State:_____ Zip_____

TO BE COMPLETED AT THE CLINIC BY THE VACCINATOR

I have received and read information regarding the vaccine(s) listed on this record. I understand the benefits and risks of the vaccine(s) and give my permission for administration of the indicated vaccine(s) for myself or the person named on this record. A health care professional has verbally reviewed the health screening questionnaire and I have answered the questions accurately to the best of my ability. I give permission for this record to be released to medical providers, health departments, school, daycare centers and others as necessary.

_____ _____
SIGNATURE - Patient, Parent or Guardian Date

Vaccine	Route IM SQ ID Other_____	Date Given	Site LD RD LVL RVL LT RT	Vaccine Lot #	Manf.	Vac. Trade Name	Person Giving Vac.
			VIS Date	Date VIS Given			