University Health Services
Immunization and Screening Informed Consent and Record

University of Maryland, Baltimore County (UMBC)
1000 Hilltop Circle
Baltimore Maryland 21250 (410) 455-2542

This record will be kept in your U.M.B.C. medical file. It contains information about which vaccine or screening test was given, when the vaccine or screening test was given, the manufacturer of the vaccine or tuberculin purified protein derivative, lot number, expiration date, and person who administered the vaccine or screening test. You may request a personal copy of this immunization/screening record sheet.

Complete the solid boxed areas on the front and back (please print):

Name: **Last**	**First**	**Middle Initial**	
Address:	**City**	**State**	**Zip Code**
Social Security Number: - -	**Birth date**	**Age**	**Gender**

Do you have an allergy to any of the following? *Please circle allergen(s).* Aluminum, Aluminum Hydroxide, Amphotericin B, Chickens, Eggs, Gelatin, Gentamicin, 2-phenoxyethanol, Neomycin, Thimerosal, Yeast?

○ **No** ○ **Yes**

Have you ever had problems with immunizations, vaccinations, or the PPD (Mantoux) test?

○ **No** ○ **Yes**

Are you pregnant, believe that you may be pregnant, or intend to get pregnant in the near future?

○ **No** ○ **Yes**

Are you ill, do you have a weakened immune system, have close contact with a person with a weakened immune system, take steroid medications, or take anti-cancer drugs?

○ **No** ○ **Yes**

Have you received any other immunizations or vaccinations, specifically MMR (measles, mumps, rubella) or Varicella (chicken pox), within the past 4-6 weeks?

○ **No** ○ **Yes**

Have you ever been exposed to tuberculosis, had tuberculosis, had a positive tuberculosis skin test, or had a positive PPD (Mantoux) test?

○ **No** ○ **Yes**

Have you ever taken drugs for active tuberculosis or a positive PPD (Mantoux) test?

○ **No** ○ **Yes**

Have you ever received the BCG (anti-tuberculosis) vaccine?

○ **No** ○ **Yes**

Have you ever had a chest x-ray to screen for tuberculosis?

○ **No** ○ **Yes**

Immunization/Screening to be given (please mark only one):

- O **Hepatitis A Vaccine**
- O **Hepatitis B Vaccine**
- O **Influenza (flu) Vaccine**
- O **Lyme Disease Vaccine**
- O **Menomune (Meningococcal) Vaccine**
- O **MMR (Measles, Mumps, Rubella) Vaccine**
- O **PPD (Tuberculin Purified Protein Derivative)/Tuberculosis Skin Test**
- O **Rabies Vaccine (pre-exposure)**
- O **Td (Tetanus/Diphtheria) Vaccine**
- O **Varicella (Chicken Pox) Vaccine**
- O **Other (Must be specified)**

"I have read or have had explained to me information about the above marked immunization or screening test. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks associated with immunization and screening tests. I ask that the following marked immunization or screening test be administered."

Signature of person to receive vaccine or screening test or person authorized to make the request:

____ Date ___________

OFFICE USE ONLY:

O Vaccine Information Statement given Date of VIS ____________________

Manufacturer ________________ Lot ________________ Expiration Date ________________

Site: ___ R ___ L ___ Deltoid ___ Upper Arm ___ Forearm

Dose ______ ml Route ___ IM ___ SC ___ ID ___ Other ____________________

Signature of person reviewing informed consent and administering vaccine or screening test:

________________________________ Title/Credentials _______________ Date __________

if PPD:

________________ mm induration O negative O positive

Referral Given: O yes O no

Follow-Up/Other Comments____

Signature of person reading PPD: ____

________________________________ Title/Credentials ________________ Date ____________

nww/Immunization and Screening Informed Consent.032204