Longview Clinic
3331 Washington Way
Longview, WA 98632
360.578.2527 voice
360.575.1460 fax
www.hwnw.org

HealthWorks Northwest

Chehalis Clinic
1522-A Bishop Road
Chehalis, WA 98532
360.740.0444 voice
360.740.0704 fax
www.hwnw.org

IMMUNIZATION CONSENT & RECORD

I have read the information forms about Tetanus, Measles, Mumps, Rubella, Influenza, PPD Skin test, Hepatitis A and Hepatitis B. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of Tetanus, Measles, Mumps, Rubella, Influenza, PPD Skin test Hepatitis A and Hepatitis B vaccines and request that the vaccines checked below be given to me or to the person named below for whom I am authorized to make this request.

Please answer the following questions:

Do you have any allergies to medicines?	☐ Yes ☐ No	Have you had a serious reaction to vaccine components?	☐ Yes ☐ No
Are you pregnant, or trying to become pregnant?	☐ Yes ☐ No	Are you allergic to eggs or feathers?	☐ Yes ☐ No
Are you nursing a baby at this time?	☐ Yes ☐ No	Have you had BCG vaccine or history of positive PPD test?	☐ Yes ☐ No
Are you allergic to thimerosoll?	☐ Yes ☐ No	Do you have any illness/infection/fever at this time?	☐ Yes ☐ No
Are you immuno-compromised?	☐ Yes ☐ No		

I consent to the following immunizations:

☐ Tetanus ☐ Hepatitis A ☐ Hepatitis B ☐ Influenza ☐ PPD Skin testing ☐ Measles, Mumps, Rubella

_____ _____/____/____
Last Name First Initial Birthdate

_____ **XXX/XX/**_____
Signature ID or Last 4 Digits of Social Security #

Your Company Name: _____

VACCINATIONS

	Date	Route	Site	Amount	Lot #	Manufact.	VIS date	Given by	PPD read date **time** & results
HBV #1		IM	deltoid	1.0 cc			7-11-01		
HBV #2		IM	deltoid	1.0 cc			7-11-01		
HBV #3		IM	deltoid	1.0 cc			7-11-01		
HAV #1		IM	deltoid	1.0 cc			8-04-04		
HAV #2		IM	deltoid	1.0 cc			8-04-04		
Influenza		IM	deltoid	0.5 cc			10-20-05		
MMR		Sub q	U. arm				01-15-03		
TD		IM	deltoid	0.5 cc			6-10-94		
Pneumonia							7-29-97		
PPD **time** given		ID	FA	0.1cc			1997		