EFFINGHAM COUNTY HEALTH DEPARTMENT
VACCINE ADMINISTRATION RECORD

_____ _____

Client Name Date of Birth

For Clients: The following questions will help us determine which vaccines may be given today. If you answer "yes" to any, it does not necessarily mean the client should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

QUESTIONS	YES	NO
1. Is the client sick today?		
2. Does the client have allergies to medications, eggs, gelatins, neomycin, baker's yeast, latex or any vaccines? (Please circle which allergy if yes)		
3. Has the client had a serious reaction to a vaccine in the past?		
4. Has the client had any of the following: long term health problem with heart, lung, kidney or metabolic disease (i.e. Diabetes), asthma, a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak? Are you on long term aspirin therapy?		
5. Does the client have cancer, leukemia, HIV/AIDS or any other immune system issue?		
6. Has the client, a sibling, or a parent had a seizure, any brain or other nervous system problems? Has the client had Guillain Barré Syndrome?		
7. If client is a baby, have you ever been told the infant has had intussusception (telescoping of one portion of intestine into another)?		
8. Has the client or anyone who lives with the client or takes care of the client taken cortisone, prednisone, other steroids, anticancer drugs (chemotherapy), radiation treatments or x-ray treatment in the past 3 months?		
9. In the past year has the client received a transfusion of blood or blood products, immune globulin, or an antiviral drug?		
10. For Females: Is the client pregnant or is there a chance she could become pregnant within the next three months?		
11. Has client received an immunization or a TB test within the last 30 days?		

I have read or have had explained to me the possible side effects and adverse reactions of the vaccines. I understand the benefits and risks of the vaccines and give permission for the vaccines be given to the client named above.

The Effingham County Health Department asks you to please wait 15 minutes, for safety reasons, after receiving vaccinations. You may choose to decline that request.

☐ **I agree to wait the 15 minutes.**
☐ **I choose not to wait and have been informed of the risks.**

_____ _____

Signature of Client/Parent/Guardian **Date**

Updated 7/03/2025

Client Name: _____ **D.O.B.:** _____

FOR OFFICE USE ONLY: **VFC** **317** **Private**

VACCINE ADMINISTRATION RECORD

VIS Given	Date	Vaccine	Manufacturer	Lot #	Site
	08/06/21	DTaP (Diptheria, Tetanus, Acellular Pertussis)			
	01/31/25	Hepatitis A			
	01/31/25	Hepatitis B			
	08/06/21	HIB (Haemophilus Influenzae)			
	08/06/21	HPV (Human Papillomavirus)			
	01/31/25	Influenza			
	01/31/25	Meningococcal (MCV4)			
	01/31/25	Meningococcal B			
	01/31/25	MMR (Measles, Mumps, Rubella)			
	01/31/25	MMRV (Measles, Mumps, Rubella, Varicella)			
	05/29/25	Pneumococcal 20			
	01/31/25	Polio, Inacivated (IPV)			
	10/15/21	Rotavirus			
	09/25/23 & 01/31/25	RSV Preventative Antibody/RSV Vaccine			
	08/06/21	Td (Tetanus, Diptheria)			
	01/31/25	Tdap (Tetanus, Diptheria, Pertussis)			
	01/31/25	Varicella (Chickenpox)			
	02/04/22	Zoster (Shingles)			
	01/31/25	COVID			
		DTap- Hep B- IPV			
		DTaP- IPV			

X = VIS Given R = VIS Refused Lead Collected: Yes or No Temp. _____ (Should be<100.4F)

_____Acknowledges that the questions have been reviewed. ____

_____

Signature of Nurse Administering Vaccines Date

EZ_____