

**FORT MEADE MEDDAC
IMMUNIZATION ORDER FORM**

Item No	Question or Educational Point of Information:	No	Yes	Don't Know
1	Are you sick today?			
2	Do you have a fever today?			
3	Do you have Allergies: Egg? ___ Thimerosal? ___ Neomycin? ___ Gelatin? ___ Rubber/latex ___ Drugs: _____ Preservatives/Other: _____			
4	Do you have a history of an adverse reaction to ANY vaccines in the past?			
5	Do you take a blood thinner like Coumadin OR do you have a bleeding problem ?			
6	Do you have any chronic illness ? Please list: _____			
7	Do you, or does any person, who lives with you or acts as a caregiver, have cancer, leukemia, AIDS, transplantation, or any other immune system problem ?			
8	Have you OR any person who lives with you) taken cortisone, prednisone, other steroids, anticancer drugs, or x-ray treatments in the past 3 months ?			
9	Have you received a transfusion of blood or plasma, or been given a medicine called immune (gamma) globulin in the past year ?			
10	Could you be pregnant ? Last menstrual period: _____			
11	Is there a chance that you could become pregnant in the next three months ?			

Patient Signature

Given ✓	<input type="checkbox"/> Vaccine Information Statements Provided to Patients	#	Source	Updated
	<input type="checkbox"/> Hepatitis A (Hep A)		CDC	25-Aug-98
	<input type="checkbox"/> Hepatitis B (Hep B)		CDC	9-Aug-00
	<input type="checkbox"/> Influenza		CDC	14-Apr-00
	<input type="checkbox"/> Measles, Mumps, Rubella		CDC	16-Dec-98
	<input type="checkbox"/> Pneumonia		CDC	29-Jul-97
	<input type="checkbox"/> Polio, Injection		CDC	1-Jan-00
	<input type="checkbox"/> Tetanus-Diphtheria (Td only VIS June 94)		CDC	15-Aug-97
	<input type="checkbox"/> Varicella (Chickenpox)		CDC	16-Dec-98

Vaccine Orders (Provider Signature Below):

Order	Date Last Dose (LD) or Series Complete (SC)	Vaccine Name	Dose (ml)	Route	Manufacturer & Lot Number	Site	Nurse Initials
		Diphtheria-Tetanus (dT)	0.5	IM			
		Hepatitis A # ___ of ___	1.0	IM			
		Hepatitis B # ___ of _3_ Booster # _____	1.0	IM			
		Influenza	0.5	IM			
		MMR	0.5	SQ			
		Pneumonia	0.5	SQ			
		Polio Injectable eIPV # ___ of ___	0.5	SQ			
		Varicella # ___ of _2_(rec. not required)	0.5	SQ			
		PPD (See PPD/Anergy Sheet)	0.1	ID			

Patient Instructions & Additional Doses of Vaccine Recommended:

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Patient's Identification:

Ordered by: (Circle One) AI Clinic Reserves Occupational Health	Date:
Administered by:	Date: