



Place sticker:

Student name: _____
 UIN: _____
 DOB: _____
 Age: _____
 Telephone: _____

Student address: _____

Current medications

Please list your current medication. Include prescription medication and over the counter medications/drugs:

Allergies

Please list any allergies that you may have:

Medical history

- Before receiving an injection, I will ask questions of the provider if I have any.
- I will inform the provider of any allergies BEFORE receiving the vaccine.
- I am not allergic to aluminum, neomycin, or formalin.
- I have received and read the Vaccine Information Statement on the Hepatitis A vaccine, including contraindications and side effects.
- I am not on blood thinners, anticoagulants or have a bleeding disorder.
- I understand that, as with any vaccine or drug, there is a possibility, however remote, that serious allergic reactions or even death could occur.
- I understand that I should report any adverse reactions to Health Services at (217) 206-6676.
- I am not pregnant or breast feeding.
- I do not have an acute illness or infection.
- I believe I understand the benefits and risks of the vaccine(s) and request that it be given to me.
- I agree to remain in the Health Services Clinic for 15-20 minutes following injection to be observed for any sign of adverse reaction.

Student Signature _____ Date: ____/____/____

HEALTH SERVICES USE ONLY

VIS form given: Yes No VIS form date: ____/____/____ VIS given by: _____

Hepatitis A Administration

Has advice been given about the requirements for 2 doses (a full course)? Yes No Has patient been advised of side effects (inflammation at vaccine site and slight fatigue for a day or two)? Yes No

1. Name of vaccine: _____ Lot number: _____ Expiration date: ____/____/____

Route: IM Site of vaccination: RT deltoid LT deltoid Nurse Signature: _____ Date: _____

2. Name of vaccine: _____ Lot number: _____ Expiration date: ____/____/____

Route: IM Site of vaccination: RT deltoid LT deltoid Nurse Signature: _____ Date: _____