Form #_____

# Region 3 Strategic National Stockpile
# SMALLPOX
# PATIENT MEDICAL HISTORY and CONSENT FORM

For Administrative Use Only: ☐ Initial Vaccination ☐ Revaccination (Initial PVN) _____

For Administrative Use Only: Place Patient Vaccination Number (PVN) Sticker Here

➢ ***Please PRINT the Following Information***

**Last Name:**_____ **First Name:** _____

**Middle Name:** _____ **Date of Birth:** ____/____/____ (mm/dd/yyyy) **Age:** _____ **Gender: M** ____ **F** ____

**Mother's Maiden Name:** _____ **Weight (if under 100 lbs):** _____**lbs.**

**Street Address:**_____ **City:** _____ **State:** _____ **Zip:** _____

**County:** _____ **E-mail (*optional*):** _____

**Home Phone:** (____)_____ **Alternate Phone:** (___)_____

**Do you have flu-like symptoms today (fever, aches, chills, cough)? YES NO (circle one)**
**Do you have an open cut/lesion and/or skin-sore or rash? YES NO (circle one)**
**Do you have a known latex allergy? YES NO (circle one)**

**FEMALES ONLY:**
**Are you currently pregnant or think you might be pregnant? YES NO (circle one)**
**Are you currently breastfeeding? YES NO (circle one**

**List <u>All</u> Known Allergies (food, medications, animals, etc.):**

_____

_____

**Do <u>YOU</u> (or the minor you are filling this out for) have any of the following medical conditions?**
***(Circle the correct answer for each question):***

| | | |
|---|---|---|
| YES | NO | Have had a smallpox vaccination before |
| YES | NO | History or presence of eczema and/or atopic dermatitis |
| YES | NO | Presently have other acute/chronic/exfoliative skin conditions (such as burns, impetigo, chickenpox, rash) |
| YES | NO | Immunosuppressed condition (i.e. HIV/AIDS, Cancer, Leukemia, Lupus, Organ Transplant) |
| YES | NO | Currently taking, or recently been treated with, immunosuppressive drugs, such as oral steroids, some drugs for autoimmune disease, or drugs taken after an organ transplant) |
| YES | NO | Taking cancer treatment drugs or radiation, or have taken such treatment in the past three months |
| YES | NO | History of Guillian-Barre Syndrome |
| YES | NO | Have ever had a life-threatening allergic reaction to antibiotics polymixin B, streptomycin, chlortetracycline, neomycin, or a previous dose of the smallpox vaccine |
| YES | NO | Long-term health condition such as: Heart Disease, Seizure Disorder, Kidney Disease, Liver Disease, Diabetes, Lung Disease, Asthma, Anemia, Other (please indicate)_____ |

**List Any Medications You Are Currently Taking:**

_____

_____

_____

**Additional medical information/concerns:**

_____

_____

Form #_____

## PARTICIPANT CONSENT OR REFUSAL TO RECEIVE VACCINATION OR MEDICATION

**I HAVE: 1)** Been informed of reasons why I am being vaccinated; **2)** Received the vaccine fact sheet indicating the risks and benefits of the vaccine, its side effects, and where I will be able to receive additional information if side effects were to develop; **3)** Received information about the infectious agent; **4)** Had an opportunity to have my questions answered.

**CONSENT: I understand the decision to be vaccinated is voluntary and AGREE to proceed with smallpox vaccination.**

Participant Signature/Parent or Guardian: _____ Date: _____

**REFUSAL: I understand the decision to be vaccinated is voluntary and DO NOT AGREE to proceed with smallpox vaccination.**

Participant Signature/Parent or Guardian: _____ Date: _____

_____ _____
Staff Screener Initials Date

## TO BE FILLED OUT BY CLINIC & VACCINATION STAFF ONLY

☐ **Referred for Vaccination** ☐ **Vaccination Refused**

☐ **Deferred due to medical contraindications (see below under infirmary/received counseling)**

**Name of Vaccination: SMALLPOX** **OTHER:** _____

**Vaccination Site (Circle One): LEFT ARM RIGHT ARM** **OTHER:** _____

**Vaccination Batch Information:** _____

**Manufacturer:** _____ **Dose Amount:** _____

**Vaccine Lot #:** _____ **Diluent Lot #:** _____ **Batch #:** _____

**Notes (if applicable):** _____

_____

_____

**ASK PATIENT: Have you ever received the smallpox vaccine? YES NO**

**Did the patient receive the Vaccination Fact Sheet? YES NO**

**Staff Signature:** _____ **Date:** _____

## If Patient Went to Infirmary/Received Counseling

**Counseling/Treatment Given By:**

**Name** _____ **Title:** _____

**What was the outcome? Clinician Notes:** _____

_____

_____