MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see requiring document. Form is not valid without Requiring Document, Issuance Date, Local Form Number, and Edition Date.

REQUIRING DOCUMENT *(Title and Number)*		ISSUANCE DATE
IMMUNIZATIONS	NAVHOSPPNCLAINST 6230.15C	10 Jul 2015

LOCAL FORM TITLE *(Optional)*
IMMUNIZATION ASSESSMENT

Date:_____ Time:_____

S. _____ yr. old / _____ months old If younger than 18 years old - weight _____

	Yes	No	Don't know
1. Are you sick today?	☐	☐	☐
2. Do you have allergies to medication, eggs, any vaccine, or any vaccine component?	☐	☐	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☐	☐
4. Do you, any person who lives with you, or any person in close contact have cancer, leukemia, AIDS, or any other immune system problem?	☐	☐	☐
5. Are you allergic to streptomycin, neomycin, phenol, or thimerisol?	☐	☐	☐
6. Are you allergic to latex or rubber?	☐	☐	☐
7. Do you, any person who lives with you, or any person in close contact take steroid medications (i.e., cortisone, prednisone, methylprednisolone), anticancer drugs, or x-ray treatments?	☐	☐	☐
8. Do you take or are you receiving any form of chemotherapy (cancer treatment)?	☐	☐	☐
9. Are you taking or are you receiving any medications to prevent rejection of an organ transplant?	☐	☐	☐
10. During the past year have you received a transfusion of blood or plasma, or been given a medicine called immune globulin?	☐	☐	☐
11. For Females: Are you pregnant or plan to become pregnant in the next three months?	☐	☐	☐
12. For Children and Teens: Are you currently on long-term Aspirin therapy?	☐	☐	☐
13. Have you received any **LIVE** vaccines in the last 4 weeks? (i.e, MMR, Varicella, Flumist, Proquad, Rotateq, Zostavax)	☐	☐	☐

MEDICATION RECONCILIATION - "Live Viruses" should not be given to patient with weakened immune systems. Certain medications may weaken the immune system such as steroids, chemotherapy (cancer treatment) or medication to prevent rejection after an organ transplant. Please list all current medications (including prescriptions, over-the-counter and herbals).

Patient/Parent or Guardian Signature: _____

O: Assessment reviewed and Medication Reconciliation completed. Corpsman/Nurse Signature: _____

A: ☐ No contraindications noted. Administer vaccine. See Vaccine Administration Record.
☐ Contraindications noted. Referred to Provider / Nurse.
☐ Give Live Vaccine ☐ DO NOT give Live Vaccine Vaccine(s) given: _____
☐ Provider / Nurse Signature: _____

P: Recommendation:
1. Cool compresses as needed for discomfort.
2. Notify clinic or go to ER for major side effects (see VIS).
3. Next scheduled immunization _____

Patient Education:
Learning assessment completed. Barriers identified: ☐ None ☐ Other _____
Provided education on the following:
1. Vaccine information / VIS provided, VIS offered.
2. Patients receiving vaccines today are instructed to remain in the clinic for 20 minutes after receiving vaccines due to possibility of reactions

PRACTITIONER'S NAME	PRACTITIONER'S SIGNATURE	DATE
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)*	HOSPITAL OR MEDICAL FACILITY	STATUS
	DEPARTMENT / SERVICE	RECORDS MAINTAINED AT
	SPONSOR'S NAME	SSN
	RELATIONSHIP TO SPONSOR	