JASPER COUNTY HEALTH DEPARTMENT – IOWA

Adult Immunizations- VFA

Name:	Date of Birth:
Address:	
Phone Number: Text: Y or N	Email:
Places Immunizations Received:	Primary Dr:

The following questions will help us determine which vaccines you may be given today.	Yes	No	Unsure
1. Are you sick today?			
2. Do you have allergies to medications, food, a vaccine component, or latex?			
3. Have you ever had a serious reaction after receiving a vaccine?			
4. Do you have any of the following: a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak? Are you on long-term aspirin therapy?			
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?			
6. Do you have a parent, brother, or sister with an immune system problem?			
7. In the past 6 months, have you taken medications that affect your immune system, such as steroids, or anticancer drugs; drugs for rheumatoid arthritis, Crohn's disease, or psoriasis; or radiation treatments?			
8. Have you had a seizure or a brain or other nervous system problem?			
9. Have you ever been diagnosed with a heart condition (myocarditis or pericarditis), or have you had Multisystem Inflammatory Syndrome after an infection with the virus that causes COVID-19?			
10. In the past year, have you received immune globulin, blood/blood products, or an antiviral drug?			
11. Are you pregnant?			
12. Have you received any vaccinations in the past 4 weeks?			
13. Have you ever felt dizzy or faint before, during, or after a shot?			
14. Are you anxious about getting a shot today?			

I have received VIS forms. I understand the risks and I give permission to administer immunizations.

Patient's Signature: X_____ Date: _____

**** OFFICE USE ****

Vaccine	RSV	Polio	Prevnar 20	Men B	Hep A	MMR	Varicella
VIS Date	10/19/23	8/6/21	5/12/23	8/6/21	10/15/21	8/6/21	8/6/21
Lot/Exp							
Site							
Vaccine	COVID-19	Flu	Tdap/Td	HPV	Men ACWY	Hep B	MMRV
VIS Date	10/19/23	8/6/21	8/6/21	8/6/21	8/6/21	5/12/23	8/6/21
Lot/Exp							
Site							

Nurse's Signature: Date:

☐ VFA Eligibility Completed ☐ Entered in IRIS ☐ Scanned

Next Immunization Due:

Notes:

Adult Immunization form 9.30.2024- New