Farmington Valley Visiting Nurse Association

Smallpox Consent Form

________________________________ __/__/__ ____ _______________

Name (please print) Date of Birth Age Date of Clinic Visit

_________________________________ ________________________ __________

Address City/State Zip

_____ __________ _______________________ _______________________

Sex Phone Dr's Name Dr's Address

____

social security number

Have you ever received the smallpox vaccine? ___No ___Yes Not Sure_____
Did you have a serious reaction to the smallpox vaccine? ___No ___Yes Not Sure_____
Do you have any conditions that weaken the immune system? ___No ___Yes Not Sure_____
Such as HIV/AIDS, leukemia, other cancers, organ transplant, lupus.
Explain____
Do any household contacts have a weakened immune system? ___ No ___Yes Not Sure_____
Are you pregnant, a nursing mother,
or plan to become pregnant in the next month? ___No ___Yes Not Sure_____
Are you allergic to the antibiotics, polymixin B,
streptomycin, chlortetracycline, or neomycin? ___No ___Yes Not Sure_____
Are you allergic to latex? ___No ___Yes Not Sure_____
Do you have any history of heart disease? ___No ___Yes Not Sure_____
Are you sick with a fever today? ___No ___Yes Not Sure_____
Questions? Do you want to talk to a medical professional? ___No ___Yes

Medical Screener's Signature **Date**

MEDICAL SCREENER'S COMMENTS____

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Smallpox Consent

I have read, or had explained to me, the information I received about smallpox vaccination. I have watched the "Post Event Smallpox Vaccine Video". I have had a chance to ask questions which were all answered to my satisfaction and I understand the benefits and risks of the vaccination as described. I request that the smallpox vaccination be given to me (*or the person named above for whom I am authorized to make this request)*.

Signature of recipient (or parent or guardian)

Smallpox vaccination

Injection Site ___Left arm ___Right arm 3 insertions____________ 15 insertions______________

Manufacturer & Lot Number:_________________________________

Given VIS: Dated:_________________________________

Nurse's Signature **Date**

NURSE'S COMMENTS____

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PRIVACY ACT STATEMENT

The information requested on this form, including the Social Security Number (SSN), is collected under the authority of Section 311 of the Public Health Service Act (42 U.S.C. 243), the NCVIA (42 U.S.C. 300aa-2(a)), and Section 304 of the Homeland Security Act of 2002 (Pub. L. No. 107-296). The information will be used in the analysis and follow-up of significant events associated with smallpox vaccination and to assure availability of smallpox response teams. The SSN is being collected for identity verification purposes. Furnishing the requested information, including SSN, is voluntary; however, with more complete information, public health objectives, such as adequate monitoring and follow-up of potential adverse events, are more readily achievable. Identifiable information may be shared with authorized U.S. Department of Health & Human Services' personnel and public health or cooperating medical authorities.

Patient Signature____________________________ Date____________________

Medical Screener____________________________ Date____________________