

## Vaccine Administration Record - Meningococcal (Menomune)

Name \_\_\_\_\_ Date \_\_\_\_\_

Employer/Department \_\_\_\_\_

SSN \_\_\_\_\_ Med. Record Number \_\_\_\_\_

### PLEASE PRINT

Have you ever had a reaction to the Meningococcal vaccine?  Yes  No

Have you had any vaccine in the past month?  Yes  No

Are you allergic to Thimerosal - a mercury-based preservative?  Yes  No

Do you have any bleeding disorders or are you taking any medicine to thin your blood?  Yes  No

Are you on any immunosuppressive drugs or steroids or suffer from any immune system disorder?  Yes  No

Are you currently sick with any acute or chronic illness?  Yes  No

If yes, please explain: \_\_\_\_\_

If female, is there any chance you could be pregnant?  Yes  No

If female, are you breast-feeding?  Yes  No

I have read or have had explained to me the information about the Meningococcal (Menomune) vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the Meningococcal (Menomune) vaccine. I request that the vaccine be given to me.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**DO NOT WRITE BELOW THIS LINE**

Manufacturer \_\_\_\_\_ Lot # \_\_\_\_\_ Expiration Date \_\_\_\_\_

Dose: 0.5 ml SQ Site of Injection  Right Deltoid  Left Deltoid

Injection Time \_\_\_\_\_ No reactions after \_\_\_\_\_ minutes of observation

Reaction, if any: \_\_\_\_\_ VIS Given? \_\_\_\_\_

\_\_\_\_\_  
Signature of Vaccine Administrator

\_\_\_\_\_  
Date/Time