Vaccine Administration Record - Rabies Immune Globulin

Name ______________________ **Date** ____________

Employer/Department ______________________

SSN ______________________ **Med. Record Number** ____________

PLEASE PRINT

Are you now receiving the rabies vaccine? ____Yes ____ No

Have you ever had a reaction to an immunoglobulin shot? ____Yes ____ No

Have you had any other immunizations in the past three months? ____Yes ____ No

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

Are you currently taking any medicine to thin your blood such as Coumadin or have any history of bleeding or clotting problems? ____Yes ____ No

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

Have you ever had a reaction to or were told you are allergic to glycerin? ____Yes ____ No

If you answered yes to any of the above problems, please provide details: ______________________

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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 Rabies Immune Globulin. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of Rabies Immune Globulin. I request that the vaccine be given to me.

Signature ______________________ Date ____________

DO NOT WRITE BELOW THIS LINE

Manufacturer __________ Lot # __________ Expiration Date __________

Dose: __ ml IM Site of Injection; ____ Right Gluteus ____ Left Gluteus

Injection Time __________ No reactions after __________ minutes of observation

Reaction, if any: ______________________ VIS Given? __________

______________________ ______________________

Signature of Vaccine Administrator Date/Time