

## Vaccine Administration Record - Typhoid (Typhim)

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

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

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

### PLEASE PRINT

Have you ever had a reaction to the Typhoid (Typhim) vaccine? \_\_\_ Yes \_\_\_ No

Have you had any vaccine in the past month? \_\_\_ 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 Typhoid (Typhim) 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 Typhoid (Typhim) 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