

Vaccine Administration Record - Yellow Fever

Name _____ Date _____

Employer/Department _____

SSN _____ Med. Record Number _____

PLEASE PRINT

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

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

Are you allergic to eggs? 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 Yellow Fever 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 Yellow Fever vaccine. I request that the vaccine be given to me.

Signature _____ Date _____

DO NOT WRITE BELOW THIS LINE

Manufacturer _____ Lot # _____ Expiration Date _____

Dose: 1 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 _____