VACCINEES Medical History and Consent Form

Name: _____ **Date** ____/____/_____

Date of Birth: ___/___/_____ **Gender:** ☐ Male ☐ Female

Medical History and Risk Assessment Information

Have you received chickenpox (varicella) vaccination in the last month? ☐ Yes ☐ No
Are you currently taking medication? ☐ Yes ☐ No
If yes, please list medications:_____

_____

Are you sick today? ☐ Yes ☐ No
If yes, please describe your illness (you may need to wait to be vaccinated until you get better **)** _____

_____

Do YOU have or have you had any of the following conditions?	**Yes**	**No**
1. Conditions that weaken the immune system such as HIV/AIDS, leukemia, lymphoma, or most other cancers, organ transplant, or agammaglobulinemia.	☐	☐
2. A severe autoimmune disease such as systemic lupus erythematosus (SLE) that may significantly suppress the immune system.	☐	☐
3. Currently taking, or have recently been treated with, immunosuppressive drugs like oral steroids (e.g. prednisone), some drugs for autoimmune disease, or drugs taken after an organ transplant.	☐	☐
4. Taking cancer treatment with drugs or radiation or have taken such treatment in the past three months.	☐	☐
5. Atopic Dermatitis, often called eczema (Even as a baby or child and even if the condition(s) is mild)?	☐	☐
6. Other skin problems that have made many breaks in your skin such as a rash, severe burn, impetigo, chickenpox, shingles, herpes, psoriasis, or severe acne.	☐	☐
7. Darier's disease (a skin problem that usually begins in childhood)?	☐	☐
8. Been diagnosed by a doctor as having a heart condition with or without symptoms such as previous myocardial infarction (heart attack), angina (chest pain caused by lack of blood flow to the heart), congestive heart failure, or cardiomyopathy?	☐	☐
9. A stroke or transient ischemic attack (a "mini-stroke" that produces stroke-like symptoms but no lasting damage)?	☐	☐
10. Chest pain or shortness of breath when you exert yourself (such as when you walk up stairs)?	☐	☐
11. Any other heart condition for which you are under the care of a doctor?	☐	☐
12. Had a life-threatening allergic reaction to smallpox vaccine, latex or the antibiotics polymixin B, streptomycin, chlortetracycline, or neomycin?	☐	☐
13. Are you now being treated with steroid eye drops?	☐	☐
14. Are you pregnant, might be pregnant, or might become pregnant in the next month?	☐	☐
15. In the past month, have you had any sex without using effective birth control or do you think you will have sex without using effective birth control during the month after vaccination?	☐	☐
16. Do you currently live in a household that has a child less than one year old?	☐	☐
17. Are you currently breast - feeding or pumping and then bottle-feeding breast milk?	☐	☐

IF YOU ANSWERED YES, YOU SHOULD NOT GET THE VACCINE AT THIS TIME.

Date: _____ ***Patient Name:*** _____

Do any of your HOUSEHOLD MEMBERS OR CLOSE PHYSICAL CONTACTS have any of the following conditions?

(Close contacts include anyone living in your household and anyone you have close physical contact with, such as a sex partner. They do not include friends or co-workers.)

	Yes	No
1. Conditions that weaken the immune system such as HIV/AIDS, leukemia, lymphoma, or most other cancers, organ transplant, or agammaglobulinemia.	☐	☐
2. A severe autoimmune disease such as systemic lupus erythematosus (SLE) that may significantly suppress the immune system.	☐	☐
3. Currently taking, or have recently been treated with, immunosuppressive drugs like oral steroids (e.g. prednisone), some drugs for autoimmune disease, or drugs taken after an organ transplant.	☐	☐
4. Taking cancer treatment with drugs or radiation or have taken such treatment in the past three months.	☐	☐
5. Eczema or atopic dermatitis or a history of these conditions, even in childhood or infancy.	☐	☐
6. Other skin conditions that cause breaks in the skin such as an allergic rash, severe burn, impetigo, chickenpox, shingles, or severe acne.	☐	☐
7. Have Darier's Disease (a skin problem that usually begins in childhood)?	☐	☐
8. Currently pregnant or planning to become pregnant in the next month?	☐	☐

IF YOU ANSWERED YES, YOU SHOULD NOT GET THE VACCINE AT THIS TIME.

Important:

Things I should avoid after getting vaccinated with the ACAM 2000 Smallpox vaccine:

- **For four weeks after vaccination and until the vaccination site has healed, you should avoid:**
  - **Getting pregnant**
  - **Handling infants (less than one year old)**
  - **Swimming or using Hot tubs, or any prolonged submersion in water**
  - **Donating blood**
  - **Getting a Tuberculosis (TB) or PPD (Purified Protein Derivative) as these tests may be false negative.**

I have:

- Received a copy of and have read the *Important Medication Guide ACAM2000 Vaccine* document
- Considered my own health status as well as the health status of my household members and close physical contacts
- Had the opportunity to discuss my medical concerns with my healthcare provider or a health care provider at the vaccination clinic
- Responded to the questions above to the best of my ability.

I understand the information above and agree to proceed with smallpox vaccination.

_____ _____

Patient Signature Date

_____ _____

Medical Screener Date

Date: _____ ***Patient Name:*** _____

DISPOSITION

☐ **Referred for Vaccination** ☐ **Deferred due to medical contraindications**

☐ **Vaccination refused**

Clinic personnel should pre-enter or attach this information before printing and copying the form.

Vaccination Clinic Information		**Vaccine Batch Information**			
Name	Occupational Health Consultants	**Vaccine Type**	**ACAM 2000**	**Batch #**	**N/A**
Contact	Dr. Michael A. Sauri	**Program**	**Laboratory**	**Batch Date**	**N/A**
Phone	301.738.6420	**Dilution Strength**	0.3ml 100 doses		**N/A**
Fax	301.990.3534	**Vaccine Lot#**	**VV03-019-C**	**Diluent Lot #**	
Address	2301 Research Blvd, Suite 125 Rockville, MD 20850	**Vaccine Lot Manufacturer**	**ACAMBIS**	**Diluent Lot Manufacturer**	**ACAMBIS**

Referring Organization _____ Age: _____

Sex: _____

Address _____ Prior Hx.: _____

Date of Vaccination: ___/___/_____ Arm inoculated: ☐ Left ☐ Right

Vaccine Administered by: _____

(please enter first name, last name, and professional suffix (M.D., R.N., etc)

TAKE RESPONSE

If take response evaluation is going to be conducted at another clinic site, please copy this page and send it to that location.

Take Response Clinic:

Name: Occupational Health Consultants

Address: 2301 Research Blvd, Suite 125, Rockville, MD 20850

Take Response Exam performed by:

_____

(please enter first name, last name, and professional suffix (M.D., R.N., etc)

Exam Date: ___/___/____

☐ Major

☐ Equivocal

☐ No Take

Additional Comments

☐ **Induration** ☐ **Erythema** ☐ **Drainage** ☐ **Scab formed** ☐ **Axillary LN present**

****Adverse Events should be recorded in VAERS****