Primary Care Internal Medicine of Ithaca, PLLC
217 N Aurora St
Ithaca NY 14850

VIS Acknowledgement Form

Section 1: Information about the Person to Receive Vaccine (Please Print)

Last Name:	First Name:	MI	Date of Birth / /
Street Address:	City	State	Zip Code
Home Phone:	Work Phone:	Cell Phone:	Age:	Gender:

Section 2: Please mark YES or NO for each of the following questions. If the answer is "Yes" to one or more of the following questions, a healthcare provider will discuss your options.

	Yes	No
1. Do you have a serious allergy to eggs?		
2. Do you have severe/life-threatening allergies? Please list:		
3. Do you have any of the following: auto-immune disorder, diabetes, kidney, liver, lung or heart disease?		
4. Have you ever had a flu shot?		
5. Have you ever had a serious reaction to a vaccine you received?		
6. If yes, please describe:		
7. Have you been vaccinated with any vaccine in the last thirty (30) days? Vaccine: Date: / /		
8. Have you had a fever within the last 24 hours?		
9. Have you ever had Guillain-Barré Syndrome?		
10. Are you pregnant?		

Section 3: Acknowledgement

I have been offered a copy of the "Vaccine Information Statement" for the below referenced vaccine(s). I have read or have had explained to me and understand, the information in this "Vaccine Information Statement". I give consent for the person named above to be vaccinated with the vaccine referenced below. I give my consent for the information on this form to be released to the New York State Immunization Information System (NYSIIS) for the purposes of assessment and reporting. I may withdraw my consent to share this information with New York State at any time.

Signature: _____ Date: / /

Flu Hep A Hep B Pneumovax23 Prevnar13 Shingrix TD TDAP

Other: _____ **Please circle vaccine being administered**

Vaccine	Dose(1st,2nd,3rd)	Date Given / /	Manufacturer	Lot #	Exp Date / /	Date on VIS / /	Initial & Title
		/ /		Lot #	/ /	/ /	
		/ /		Lot #	/ /	/ /	