82 Norwich-Westerly Road
North Stonington CT 06359

North Stonington Medical Walk-In Center, PC

Phone: (860)599-2469
Fax : (860)599-2830

Bacterial Meningitis Vaccine (Menactra) Authorization

Name:_____ Date of Birth_____

Street Address:_____

City:_____ State:_____ Zip:_____

Telephone:_____SSN:_____

Have you had the bacterial meningitis vaccine before? Yes/No
If Yes, when?_____

Have you ever had a reaction to the bacterial meningitis shot? Yes/No
If Yes, when?_____

Have you ever had a reaction to the Tetanus, Diptheria, Pertussis (DPT) shot? Yes/No

Do you have hypersensitivity to dry natural latex? Yes/No

Have you provided a complete list of current medications to our staff? Yes/No

Do you have immune deficiency? Yes/No

Are you sick with fever? Yes/No

Are you pregnant or nursing? Yes/No

I have read, or had explained to me, the information sheet relating to the bacterial meningitis vaccination. I have been given the chance to ask questions and have been provided answers by this medical practice. I understand the benefits and risks of the vaccination as described in the information sheet provided.

I request the bacterial meningitis vaccine be given to me (or to the person for whom I am authorized to make this request).

I authorize the release of any medical or other information necessary to process a Medicare or Insurance claim.

_____ _____
Signature (or Parent/Guardian) Date

For office use only:

Dose 05cc IM Injection Site: Right_____ Left_____ Arm

Manufacturer:_____

Lot:_____ Expiration:_____

Medical Staff Initials:_____ Date:_____