Varicella (Chicken Pox)
Vaccine Administration Record

Varicella (Chicken Pox) is a highly infectious disease caused by infection with varicella-zoster virus. The CDC states Varicella can be life-threatening to certain patients. Due to this fact, it is highly recommended and encouraged that health care workers (as well as non-health care workers) that have not had chicken pox or chicken pox vaccine should get the Varicella vaccination.

PLEASE PRINT

Section I

☐ **I have already received Varicella immunization on Date** _____

☐ **I accept the Varicella Vaccine** and have read the CDC Vaccine Information Statement. VIS 3/13/2008

Last Name	First Name	Date of Birth
Department Name	Department #	Employee ID #**REQUIRED**
Employer Name	Job title	Last 4 SS#

Yes	No	
☐	☐	Have you ever had a severe **allergic reaction** to neomycin, gelatin, or any components of the chicken pox vaccine?
☐	☐	Do you have a disease that affects **the immune system**?
☐	☐	Do you have any kind of cancer?
☐	☐	Are you being treated with any **steroids**, **radiation or cancer medications**?
☐	☐	Has a physician instructed you not to have Varicella vaccination?
☐	☐	Have you **received another vaccine** within the past 4 weeks?
☐	☐	Have you recently had a transfusion or received other **blood products**?
☐	☐	Are you currently **pregnant?** (*CDC recommends not getting pregnant within 4 weeks of receiving the vaccine while the manufacturer of the vaccine recommends 12 weeks*)
☐	☐	Are you currently taking Aspirin? (*CDC recommends not taking Aspirin for 6 weeks following the varicella vaccine.)*

I have read or have had explained to me the information on this form about Varicella vaccine. I have had a chance to ask questions and these were answered to my satisfaction. I understand the benefits and risks of the Varicella vaccine. I request that the Varicella vaccine be given to me.

Signature: _____ Date: _____

Section II.

☐ **I choose to waive the Varicella vaccination at this time.**

I realize I am eligible for Varicella immunization and that my refusal of it may put myself, patients, visitors, and families with whom I come in contact with at risk. Based on information from the CDC, I understand that I may acquire chickenpox by coming in contact with someone who has chickenpox or shingles.

Signature: _____ Date: _____

Office Use Only

Vaccine #1 Name/Manufacturer: _____ Lot # _____ Expiration Date: _____

Diluent Lot # _____ Expiration Date: _____

Site: ☐ Left Arm ☐ Right Arm Administrator's Signature: _____ Date: _____

Vaccine #2 Name/Manufacturer: _____ Lot # _____ Expiration Date: _____

Diluent Lot # _____ Expiration Date: _____

Site: ☐ Left Arm ☐ Right Arm Administrator's Signature: _____ Date: _____