MENINGOCOCCAL VACCINATION CONSENT FORM

General Information: Meningococcal disease is a serious illness, caused by a bacterium. It is a leading cause of bacterial meningitis in the United States. Anyone can get meningococcal disease, but it is most common in children and young adults and people with certain medical conditions, such as lack of a spleen. Meningococcal infections can be treated with drugs such as penicillin, yet, about 1 out of every ten people who get the disease dies from it, and many others are affected for life.

Further, the Centers for Disease Control and Prevention (CDC) recommend that microbiologists who are routinely exposed to meningococcal bacteria receive this vaccination. The Meningococcal conjugate vaccine Menactra (MCV4) is the preferred vaccine for people 11-55 years of age. Menomune (MPSV4) is available for people over 55 years of age. As with any vaccine, Menactra/Menomune vaccines may not protect 100% of individuals.

Common adverse reactions: The most common adverse reactions to Menactra/Menomune vaccine include pain, redness, and induration at the site of injection, headache, fatigue, and malaise.

PLEASE PRINT

Section I

☐ **I already received the Meningococcal vaccinations. Dates** _____

☐ **I accept the Meningococcal Vaccine** and have read the CDC Vaccine Information Sheet.

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

Yes	No	
☐	☐	Have you had a severe **allergic reaction** or other problems after receiving **previous Meningococcal** vaccine?
☐	☐	Have you ever had any **neurological disorders,** Guillan Barre syndrome or seizures?
☐	☐	Do you have a severe **allergy to Latex?**
☐	☐	Has a physician instructed you to not have the Meningococcal vaccine?
☐	☐	Do you have an acute infection? Fever?

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

Signature: _____ Date: _____

Section II. Waiver portion

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

Signature: _____ Date: _____

Office Use Only

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

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