

Northwest Missouri State University  
University Wellness Center  
800 University Drive  
Maryville MO 64468  
Phone 660-562-1348

**Meningococcal Menactra Vaccine Consent Form**

Name \_\_\_\_\_ 919 \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Male  Female Date of Birth: \_\_\_\_\_ Age \_\_\_\_\_ Phone \_\_\_\_\_

Home Address \_\_\_\_\_  
Street City State Zip

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 1. Are you allergic to any medications? If yes, please list   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you allergic to latex?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had a reaction to the Tetanus, Diphtheria, Pertussis (DTP) vaccine?                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you currently on steroids or chemotherapy, HIV positive, asplenic, or immunosuppressed for any reason? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. If female, are you or could you be pregnant at this time?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you felt ill or run a fever in the past 48 hours?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Please list any medications you are currently taking _____   |                          |                          |

I have read the Vaccine Information Statement "Meningococcal Vaccines What You Need To Know" most recently published by the CDC. I understand the risks and benefits of the vaccine, and consent to vaccination with Menactra vaccine.

\_\_\_\_\_  
Student Signature Date

\_\_\_\_\_  
Signature of parent or guardian (if student under the age of 18) Date

**DO NOT WRITE BELOW THIS LINE**

Temp: \_\_\_\_\_ Dose: 0.5ml injected into  IM right Deltoid  IM left Deltoid

Manufacturer/Lot No: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Nursing Signature: \_\_\_\_\_ Date: \_\_\_\_\_

CHARGE  PAID