Varicella Vaccine Consent Form

Employee Information:

Name: _____

	Yes	No
1. Have you ever had an allergic reaction to a vaccine or medication?	_____	
2. Are you allergic to neomycin or gelatin ?	_____	
3. Are you pregnant or breast- feeding?		_____
4. Are you under a physicians care?		
5. Are you currently ill, fever or cold?		_____
6. In the past 5 months, have you received a blood transfusion		_____
7. Have you received Immune globulin or varicella immune globulin (VZIG) ?		_____

Consent:

I have read the information packet on VARIVAX (chickenpox vaccine). I have been given the opportunity to ask questions, and I understand the benefits and risks associated with this vaccine. I understand that I should avoid becoming pregnant for 3 months following receipt of this vaccine, and that I should avoid the use of aspirin for 6 weeks after vaccination. If I develop a rash, I must remain off work until the rash subsides and receive clearance from Infection Control/Safety Officer to return to work.

Signed _____ **Date** _____