****

**IMMUNIZATION CONSENT AND RECORD**

CLINIC SITE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Complete all highlighted sections**

|  |
| --- |
| **PATIENT AND INSURANCE/PAYMENT INFORMATION**NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SEX (M)\_\_\_\_\_\_\_\_(F)\_\_\_\_\_\_\_\_\_ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ APT \_\_\_\_\_\_\_\_\_\_\_CITY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE \_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE (1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SOCIAL SECURITY NUMBER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PRIMARY INSURANCE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ID #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GROUP #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SECONDARYINSURANCE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ID #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GROUP #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Other Payment**Cash \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Check\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Credit Card\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PATIENT SCREENING INFORMATION**The following questions will help us determine which vaccines you may be given today. If you answer “yes” to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Yes | No | Don’t Know | Comments: |
| **INFLUENZA ONLY**  |  |  |  |
| 1. Are you sick today? |  |  |  |
| 2. Do you have allergies to medications, egg, vaccines, or latex? |  |  |  |
| 3. Have you ever had a serious reaction after receiving a vaccine? |  |  |  |
| 4. Have you had a seizure, a brain or nervous system problem or Guillain-Barre Syndrome? |  |  |  |
| 5. Have you received a vaccine in the last 4 weeks? |  |  |  |
| **OTHER IMMUNIZATIONS** |  |  |  |
| 6. For women: Are you pregnant or is there a chance you could become pregnant during the next month? |  |  |  |
| 7. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease, anemia or other blood disorder? |  |  |  |
| 8. Do you or anyone living in your household have cancer, leukemia, HIV/AIDS or any other immune system problem? |  |  |  |
| 9. Do you have any problems with your immune system or take medications which affect your immune system? |  |  |  |
| 10. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? |  |  |  |

(**PATIENT**) Questions answered by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(**VACCINE ADMINISTRATOR**) Responses Reviewed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Contraindications present? Yes/No If Yes, explain: |

|  |
| --- |
| **PATIENT CONSENT*** I have had a chance to ask questions and they were answered to my satisfaction. I believe I understand the benefits and the risks and ask that the vaccine or injection be given to me or to the person named for whom I am authorized to make this request.
* I have received a copy of the Vaccine Information Statement (VIS) for the vaccine that I will receive today. I have read or have had explained to me the information provided to me regarding the vaccines I will be receiving. I understand that I will need additional doses of the Hepatitis, Chicken Pox and/or Gardasil vaccines for long term protection.

\_\_ Influenza (*One dose*)\_\_ Pneumovax 23 (PPSV23) (*One dose*)\_\_ Prevnar 13 (PCV13) (*One dose*)\_\_ Hepatitis A (Havrix) (*One additional dose required at six months*)\_\_ Hepatitis B (Energix) *(Two additional doses required at one month and six months)*\_\_ Twinrix (Hepatitis A and Hepatitis B) *(Two additional doses required at one and six months)*\_\_ Td (Tetanus, Diptheria) *(One dose)*\_\_ Tdap (Tetanus, Diphtheria, Pertussis) *(One dose)*\_\_ Shingles(Zostavax) *(One dose)*\_\_ Chicken Pox (Varicella) *(One additional dose at one month)*\_\_ MMR (Measles, Mumps, Rubella) *(One dose)*\_\_ HPV (Gardasil 9) (Human Papilloma virus) *(One/Two additional doses required depending on age)*\_\_ Meningococcal ACWY Vaccine (Menactra/Menveo) *(One dose)**\_\_* Meningococcal B Vaccine (Bexsero) *(One additional dose required at two months)*\_\_ Other Vaccine\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* I have received a copy of the Notice of Privacy Practices.
* Financial Responsibility:

By my signature below, I acknowledge that I have received the vaccine as indicated and I authorize my provider to bill and collect from my insurance for the vaccine and related administration fees. I understand that this authorization does not release me from any financial responsibilities (co-payments or deductibles) required under my plan. I have been notified that my insurance may deny payment entirely or partially for the vaccine or injection. If my insurance denies payment for the entire amount or for a partial amount, I agree to be personally and fully responsible for payment.Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |