



ADULT 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) _____ LAST 4 DIGITS of SOCIAL SECURITY NUMBER _____

INSURANCE COMPANY'S FULL NAME _____

ID # _____ GROUP # _____

SECONDARY INSURANCE COMPANY'S FULL NAME _____

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, Meningococcal B and/or Human Papilloma vaccines for long term protection.

- Influenza (*One dose*)
- Hepatitis A and Hepatitis B Combo- Twinrix (*Two additional doses required at one and six months*)
- Hepatitis A Pediatric- Havrix 720ELU/ml (*One additional dose required at six to twelve months later*)
- Hepatitis A Adult- VAQTA (*One additional dose required six to eighteen months later*)
- Hepatitis B Pediatric- Energix-B 10mcg/0.5ml (*Two additional doses required at one month & six month later*)
- Hepatitis B Adult- Energix-B 20mcg/1.0ml (*Two additional doses required at one month and six months*)
- Human Papilloma (HPV)- Gardasil 9 (*One/Two additional doses required depending on age*)
- Measles, Mumps, Rubella- MMR II (*One dose*)
- Meningococcal ACWY- Menveo (*One dose*)
- Meningococcal B- Bexsero (*2 doses at least one month apart*)
- Pneumonia conjugate (PCV13) - Prevnar 13 (*One dose*)
- Pneumonia polysaccharide (PPSV23) - Pneumovax 23 (*One dose*)
- Shingles- Shingrix (*One additional dose required two to six months later*)
- Tetanus, Diphtheria (Td) (*One dose*)
- Tetanus, Diphtheria, Pertussis (Tdap)- Boostrix (*One dose*)
- Chicken Pox (Varicella)- Varivax (*One additional dose at one month*)
- 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: _____

VACCINE(S) ADMINISTERED (To Be Completed By Vaccine Administrator) PATIENT NAME: _____

Codes for Vaccine

- | | |
|---|--|
| Flulaval- Quadrivalent (age 6 mo+) _____ 90688 | MMR II- MeaslesMumpsRubella (ages 12 mo+) _____ 90707 |
| Fluad - Trivalent HD Flu (ages 65+) _____ 90653 | Menveo- Meningitis ACWY (ages 2 mo- 55 yrs) _____ 90734 |
| Afluaia- Quadrivalent (ages 6 mo+) _____ 90656 | Bexsero- Meningitis B (ages 10-25, 2 doses 1 month apart) _____ 90620 |
| Flu Mist – Quadrivalent (ages 2-49) _____ 90672 | Pprevnar 13- PCV13 (ages 65+ or with w/chronic illness) _____ 90670 |
| Flucelvax- Quad Pres Free (ages 18+) _____ 90674 | Pneumovax 23- PPSV23 (ages 65+ or w/chronic illness) _____ 90732 |
| Twinrix- Hep A & Hep B (ages 18+, 3 doses 0, 1, 6 mo) _____ 90636 | Shingrix- Shingles (ages 50+, 2 doses 0, 2-6 mo) _____ 90750 |
| Havrix 720ELU/0.5ml <u>Hepatitis A Pediatrics</u> (ages 1+, 2 doses 0, 6-12 mo) ____ 90633 | Adecel- TD/Tetanus, Diphtheria only (ages 10-64yrs) _____ 90714 |
| Vaqta- 1.0 ml <u>Hepatitis A Adults</u> (ages 1+, 2 doses 0, 6-12 mo) _____ 90632 | Boostrix- TDAP/Tetanus Diphtheria Pertusis (ages 10+) _____ 90715 |
| Energix-B 10mccg/0.5- <u>Hepatitis B Pediatrics</u> (ages 0-19, 3 doses 0, 1, 6 mo) ____ 90744 | Varivax- Chicken Pox (ages 12 mo- 12yr, 2 doses 3 mo. apart) ____ 90716 |
| Energix- B 20mccg/1.0ml- <u>Hepatitis B Adults</u> (ages 20+, 3 doses 0, 1, 6 mo) ____ 90746 | Varivax- Chicken Pox (ages 13+, 2 doses 4 weeks apart) _____ 90716 |
| Gardasil 9- HPV (ages 9-26, 2 doses 0, 6-12mo) _____ 90651 | |
| Gardasil 9- HPV (ages 15-36, 3 doses 0, 2, 6 mo) _____ 90651 | Other Vaccine: _____ CPT code: _____ |

Codes for Administration of Vaccine

Administration, 1 vaccine _____ 90471	MEDICARE- Any Flu Administration _____ G0008
Administration, each additional vaccine _____ 90472	MEDICARE- Any Pneumonia _____ G0009
Administration Administration for 1 FluMist _____ 90473	MEDICARE- Hep B Administration _____ G0010
Administration for FluMist PLUS Additional vaccine _____ 90474	

Vaccine Administration Record

Vaccine	Date Administered	Site and Route	Manufacturer / Lot No.	Current VIS Date	Date VIS given to patient
Influenza				8/7/2015	
Twinrix Combination Hep A & Hep B				7/20/2016	
Havrix for Pediatrics & Vaqta for Adults Hepatitis A				7/20/2016	
Energix for Pediatrics & Adults Hepatitis B				7/20/2016	
Gardasil 9 HPV				12/2/2016	
MMR II Measles, Mumps, Rubella				2/12/2018	
Menveo Meningitis ACWY				8/24/2018	
Bexsero Meningitis B				8/9/2016	
Pprevnar 13 Pneumonia conjugate PCV13				11/5/2015	
Pneumovax 23 Pneumonia polysaccharide PPSV23				4/24/2015	
Shingrix Shingles				2/12/2018	
TD Texanus Toxoid/Diphtheria				4/11/17	
Boostrix Tdap				2/24/2015	
Varivax Chicken Pox				2/12/2018	
Other					

Vaccine(s) administered by: _____ Title: _____

(rev. 7/18/19)