Carroll County Health Department Consent Form for Adult Immunization

All services provided on a non-discriminatory basis.

Last Name	First Name	MI	DCN/SSN	Date of Birth / /	☐ Male ☐ Female
Street Address	City	State	Zip Code	Phone#	Check all that apply ☐ Medicaid ☐ Uninsured ☐ Private Insurance

Race (select all that apply): ☐Amer Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Native Hawaiian or other Pacific Islander ☐ Bi Racial or Multi Racial

Ethnicity: ☐ Non-Hispanic or Latino ☐ Hispanic or Latino

If you have **private insurance**, does it pay for immunizations? ☐ Yes ☐ No ☐ Don't Know
(If yes, please complete the following)

Primary Insurance Name_____ Member ID#_____ Group ID#_____
Relationship to Insured_____ Insured First Name_____Insured Last Name_____
Insured Date Of Birth____/____/_____ Insured Gender- F / M

*I give the Carroll County Health Department permission to share my medical record with the above insurance company for billing purposes.

Signature of person authorized to make the request_____Date____/____/_____

	YES	NO	Don't Know
1. Are you sick today?	☐	☐	☐
2. Do you have allergies to medications, food (eggs), a vaccine component or latex?	☐	☐	☐
3. Have you had a serious reaction to a vaccine in the past?	☐	☐	☐
4. Have you had a health problem with lung, heart, kidney or metabolic disease, Asthma , or a blood disorder?	☐	☐	☐
5. Are you on long term aspirin therapy?	☐	☐	☐
6. Have you had brain or other nervous system problems? (seizures / Guillain- Barre Syndrome)	☐	☐	☐
7. Do you have cancer, leukemia, AIDS or any other immune system problem?	☐	☐	☐
8. In the past 3 months, have you taken cortisone, prednisone, other steroids, anticancer drugs, or had radiation treatments?	☐	☐	☐
9. In the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
10. Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
11. Have you received vaccinations in the past 4 weeks?	☐	☐	☐
12. Will you be visiting or taking care of someone, within the next 7 days, who requires a protected environment?	☐	☐	☐

Your Doctor_____ Your weight_____

*I have been given a copy and have read, or had explained to me the information in the "Vaccine Information Statement(s)," where applicable, for the vaccine(s) indicated below. I have had a chance to ask questions and had them answered to my satisfaction. I understand the benefits and risks of the vaccine(s) requested and ask that the vaccine(s) currently due for which I have signed below be given to me or to the person named above for whom I am authorized pursuant to Section 431.058,RSMO to make this request.

*I authorize the release of my complete medical record, as it is available to the Carroll County Health Department, to those entities who request it with a legitimate cause for use of this information; including but not limited to: educational institutions, childcare facilities, employers and physicians' offices. I hereby release the Carroll County Health Department and its employees there in from any liability for releasing such information pursuant to this authorization.

X_____/_____/_____

Signature of person authorized to make the request Print Date

FOR CLINIC USE ONLY- TO BE FILLED IN BY NURSING STAFF						
☐ First Vaccines	11/5/15	☐ DTaP/DT	5/17/07	☐ Tdap	2/24/15	
☐ Rotavirus	4/15/15	☐ Polio	7/20/16	☐ MCV4/MPSV4	3/31/16	
☐ MMR	4/20/12	☐ Hib	4/2/15	☐ MenB	8/14/15	
☐ Chickenpox	3/13/08	☐ PCV 13	11/5/15	☐ HPV -Gardasil 9	3/31/16	Temperature _____ ☐ N/A
☐ Hep A	7/20/16	☐ MMRV	5/21/10	☐ Shingles	10/6/09	☐ No immunization record
☐ Hep B	7/20/16	☐ Td	2/24/15	☐ Influenza		☐ Refused VIS forms

Appropriate VIS forms offered ☐
Signatures on consent form ☐
Discussed immunization(s) and possible side effects ☐
Notified to wait 10 minutes after injection(s) ☐

Nurse's Signature/Title_____Date: ____/____/_____

Rvs7/16 cam