NCDHD North Central District Health Department

Vaccination Consent Form – Adult (19+)

Follow-Up:

LAST NAME	FIRST NAME		MIDDLE INITIAL
AGE	BIRTHDATE	GENDER (circle)	Male/Female
STREET ADDRESS	MAILING ADDRESS (IF DIFFERENT)		
CITY	STATE	ZIP	PHONE #

MOTHER'S MAIDEN NAME (First and Last):	Primary language, if other than English:	ETHNICITY	☐ Not Hispanic or Latino ☐ Hispanic or Latino
RACE	☐ White ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ Other:		

2.	Are you sick today?		YES	NO
3.	Do you have allergies to medications, gelatin, yeast, eggs, latex or any vaccine?		YES	NO
4.	Have you ever had a serious reaction to a vaccine in the past?		YES	NO
5.	Have you had a seizure or a neurological problem?		YES	NO
6.	Do you have cancer, leukemia, AIDS or any other immune system problem?		YES	NO
7.	Do you take cortisone, prednisone, other steroids, anticancer drugs or X-Ray treatment?		YES	NO
8.	Have you received a transfusion of blood or blood products or been given immune (gamma) globulin or an antiviral drug in the past 6 months?		YES	NO
9.	Are you pregnant or is there a chance you could become pregnant during the next 3 months?	N A	YES	NO
10.	Have you had chicken pox?		YES	NO
11.	Have you ever had Guillian-Barre syndrome?		YES	NO
11.	Have you received vaccinations in the past 4 weeks?		YES	NO

INSURANCE QUESTIONS

Do you have health insurance, including Medicaid or Medicare?	**YES**		**NO**
If yes, does your health insurance cover vaccines?	**YES**	**YES, BUT NOT ALL**	**NO**

I GIVE CONSENT to North Central District Health Department and its staff to vaccinate the person listed on this form. I have received and read or had explained to me the Vaccine Information Statement(s) and understand the risks and benefits. I also acknowledge that North Central District Health Department has made their Notice of Privacy available for review. I understand that I may request a copy of the Notice of Privacy. I hereby grant permission to North Central District Health Department to release any pertinent information to the insurance carrier listed on the reverse side upon request and any physicians to whom I might be referred. If not eligible for Vaccines for Children Program (VFC) or Adult Immunization Program (AIP), I understand that I am responsible for charges not paid by my insurance company.

Signature:	Date:

WE REQUEST THAT YOU STAY ON SITE FOR 10 MINUTES AFTER RECEIVING YOUR VACCINATION(S). IF YOU CHOOSE TO LEAVE, YOU ASSUME ALL RESPONSIBILITY/LIABILITY FOR ANY ADVERSE EVENT. THANK YOU.

ADMINISTRATIVE USE ONLY

CHECK VACCINES TO BE RECEIVED:

☐ **Influenza** ☐ **Td/Tdap** ☐ **Shingles** ☐ **Pneumococcal** ☐ **Meningococcal**
☐ **MMR** ☐ **HPV** ☐ **Chickenpox** ☐ **Hepatitis A** ☐ **Hepatitis B** ☐ **Hib**

Vaccine Name	Manufacturer	Lot Number	Expiration Date	Date Given	Site	
	GSK Merck Sanofi Pasteur				RA	LA
					RT	LT
Nurse Signature:						

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CLINIC SITE:	NESIIS Entry Date:	Billed Date:
	NESIIS Entry Initials:	Billed Initials:

Payment Information (check all that apply):			
☐ Cash	**For insurance, including Medicaid or Medicare, fill out information to right:**	Insurance Company:	☐ BCBS ☐ Cov ☐ MC ☐ UHC ☐ Mcaid ☐ Mcare ☐ Other
☐ Check		Primary Policyholder	
☐ Donation		Relationship to Insured	☐ Self ☐ Spouse ☐ Parent
☐ VFC		Policy/Member #	
☐ AIP		Group #	
☐ Insurance		Payer ID	
☐ Bill to:			