Immunization Consent Form

Patient Demographic Information

Patient Name: ☐M ☐F **DOB:** ___/___/___ **Age**_____

_____

Last ***First*** ***M.I***

Mailing Address:_____ **Apt # :** _____

City:_____ **State:** _____ **Zip:** _____**Phone:** (___)_____-_____

Email:_____

Please check vaccines which you or your child is receiving at this clinic:

☐HPV ☐ Meningococcal ☐ TDap ☐Varicella ☐ Flu

Insurance Information

☐None/Self Pay ☐ Insurance ☐ Employer is paying

If we have a copy of the insurance card only fill out the **

Name of Employer: _____

Name of Insurance: _____ **ID#** _____**Group #** _____

****Subscriber's Name:** _____**DOB:** _____

****Subscriber's SSN:**_____

****Relationship To Patient:**_____

****PLEASE MAKE SURE INSURANCE INFORMAITON IS COMPLETE. IF WE ARE UNABLE TO BILL INSURANCE WE WILL BILL PATIENT OR PARENT/GUEARDIANS. WE NEED COPIES OF ALL IINSURANCE CARDS****

Acknowledgement and Consent

All patients or parents/ guardians please check each box and sign and date the signature box below.

- ☐ I have read or have had explained to me the information contained in the Vaccine Information Statement (s) about the Diseases (s) and the vaccine (s). I have had a chance to ask questions which was answered to my satisfaction.
- ☐ I understand the benefits and risks of the vaccine (s) and request the vaccine (s) and request the vaccine (s) to the person name above for whom I am authorized to make this request.
- ☐ I have received and reviewed the Notice of Privacy Practices, which provides a description of information uses and disclosure.
- ☐ I consent to the share use of demographic information and authorize my immunization records to be recorded into the State of Montana Immunization Registry for immunization health purposes and that it may be released to health care providers, child care providers and schools across the state that may provide continuing immunization services. I understand that I can revoke this authorization and have my record removed at any time by contacting my local county health department.
- ☐ I authorize payment of medical benefits to this county health department for services rendered. I understand that the patient or parent/guardian is responsible for any unpaid balances. I understand that any unpaid balance may be sent to a collections agency.
- ☐ I understand that if I am traveling for a extended period of time and will be able to receive communication from the health department regarding a balance on my account, I must designate a responsible party to pay any unpaid balance. I understand that I still maintain full responsibility for the payment of the bill, regarding of this designation.

Signature: _____ **Date:** _____

Please answer the Health Questions on the Back

Patient Name: _____ **DOB:** _____

PLEASE READ CAREFULLY AND CHECK YES OR NO. THE NURSE WILL DISCUSS ANY YES RESPONSES WITH YOU.

IS THE PERSON RECEIVING THE IMMUNIZATIONS:

Taking any medications? Please list: _____		❑Yes	❑No
If requesting a TB skin test, list results of previous skin test. ❑Negative ❑Positive Date: _____			
Have or had convulsions, seizures or had previous serious vaccine reactions?		❑Yes	❑No
Taking Corticosteroids?	**(MMR, Varicella, YF, LAIV, Shingles)**	❑Yes	❑No
Allergic to Chicken Eggs? (anaphylactic, hives, swelling of mouth and throat, difficult breathing)	**(Flu, YF)**	❑Yes	❑No
Allergic to yeast? (anaphylactic, hives, swelling of mouth and throat, difficult breathing)	**(Hep8, HPV, Oral, Typhoid)**	❑Yes	❑No
Allergic to Gelatin?	**(Varicella, YF, Shingles)**	❑Yes	❑No
Allergic to Streptomycin, Neomycin, or Polymixin B?	**(MMR, IPV, Varicella, Shingles)**	❑Yes	❑No
Allergic to Latex?	**(Flu, Multidose Rotarix)**	❑Yes	❑No
Allergic to Thimerisol?	**(Flu, Multidose Vial)**	❑Yes	❑No
Has or have other Allergies? List here: _____		❑Yes	❑No
Have active tuberculosis?	**(MMR,YF, LAIV, Varicella Shingles)**	❑Yes	❑No
Have cancer, leukemia, immune problems or other chronic disease?	**(MMR,OPV,YF, Varicella Shingles)**	❑Yes	❑No
Living with someone who is being treated for cancer, has immune problems, or other serious illness?	**(Live Vaccines)**	❑Yes	❑No
Had any live virus in the past 30 days?	**(MMR,YF, LAIV, Varicella Shingles)**	❑Yes	❑No
Have congenital or heredity immune problems?	**(Live Vaccines)**	❑Yes	❑No
Received blood procedures, transfusions, plasma, organ or stem cell transplant or been given a medicine called immune globulin during the past several months?	**(MMR,YF, LAIV, Varicella Shingles)**	❑Yes	❑No
Sick today, or have/had an acute illness with fever within the last twenty-four hours?		❑Yes	❑No

FOR STAFF USE ONLY

☐ **EMPLOYEER** ☐ **SELF** ☐ **PRIVATE** ☐ **VFC** ☐ **IMMTRAX**

Clinic Date: _____ Nurse Signature _____

Vaccine	Lot Number/EXP	Dose/Dosage	Site	Vaccine	Lot Number/EXP	Dose/Dosage	Site
Flu Shot			**L R Arm**				
Flu Mist/Age 2-49							
Tdap		**1**	**L R Arm**				
Meningoccal-Meningtitis/ Menactra		**1 2**	**L R Arm**				
Hep B		**1 2 3**	**L R Arm**				
HPV/AGE 9-23		**1 2 3**	**L R Arm**				
Varicella/C Pox		**1 2**	**L R Arm**				