**** **Adult Immunization Consent Form**

**Please complete the following information.**

Place patient sticker here

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| **Patient Information** |  |
| Patient’s Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Patient’s First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_M.I.\_\_\_\_\_\_\_ Patient’s DOB: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age\_\_\_\_\_\_\_\_ □Male □Female  Month Day YearPhone Number: \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt: \_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_Place of Birth: (State or Country) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Patient’s ethnicity is? (Circle) White Hispanic Black Asian Filipino Pacific Islander American Indian Alaskan Native Other\_\_\_\_\_\_\_\_\_Primary language (Circle): English Spanish Other(list):\_\_\_\_\_\_\_\_\_ | **Insurance status and/or type of insurance** |
| □No Insurance□Medicaid □Private Insurance - Patient must pay full price of vaccine at the time of visit. A receipt will be provided and the patient can submit a personal request to be reimbursed through their insurance carrier. Carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |
| **Screening questions** - *If a question is not clear, please ask.* | **Yes** | **No** | **Unsure** |
| 1. Are you sick today? | **□** | **□** | **□** |
| 2. Have you had a **severe reaction** to a medication, food, or vaccine in the past?  | **□**  | **□**  | **□**  |
| 3. Has a healthcare provider told that you have **asthma**?  | **□**  | **□**  | **□**  |
| 4. Have you had a seizure, brain, nervous system problem, or had Guillain-Barre Syndrome? | **□**  | **□**  | **□**  |
| 5. Do you, or have you ever had cancer, leukemia, lymphoma, other malignancies, HIV / AIDS, complement deficiency, your spleen removed, an organ transplant, immune system problem, thymus disease, thymoma, Myasthenia Gravis, DiGeorge Syndrome or **any other long-term health problems**? **Please state:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **□**  | **□**  | **□**  |
| 6. Are you taking steroids (cortisone/prednisone), or been on steroid therapy within the past month. Have you been medically treated with anticancer drugs (chemotherapy), or had radiation therapy in the **past three months**? Are you receiving antiviral drugs? | **□**  | **□**  | **□**  |
| 7. Are you taking aspirin or products containing aspirin? | **□**  | **□**  | **□**  |
| 8. Have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin in the **past year**?  | **□**  | **□**  | **□**  |
| 9. Are you pregnant, planning on becoming pregnant in the next month or sexually active and not using birth control?  | **□**  | **□**  | **□**  |
| 10. Have you had a live vaccine in the last 4 weeks? (MMR, Varicella, Shingles and/or flu mist) | **□**  | **□**  | **□**  |
| 11. Do you use tobacco? | **□**  | **□**  |  |
|  |
| Authorization |
| 1. | I have read or have had explained to me the information contained in the Vaccine Information Sheets for each vaccine. I have had the chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) indicated below be given to me. |
| 2. | I authorize the vaccine information to be put into the Colorado Immunization Information System (CIIS), under the Colorado Immunization Act. I can choose to exclude the vaccine information from CIIS by asking the Clinic staff for instructions.  |
| 3. | I authorize the release of information to or from: a health care provider, clinic, hospital, public health agency, school, and the CIIS. I understand the information will be released for the specific purpose of verifying immunization status. This authorization will remain valid for five (5) years from the signature date. I can take back this authorization by telling Denver Public Health in writing at any time. |
| 4. | If I have Medicaid (or another accepted insurance), I authorize DHHA to bill and collect payment from the insurance carrier, and the insurance carrier is directed to make payment to DHHA.  |
| 5.  | By signing below, I certify to the accuracy of the above patient information and I give consent for immunization services provided by Denver Public Health. |
| 6.  | I have been advised that I should stay seated within the clinic area for 15 minutes after receiving vaccines to prevent possible injury from fainting. |
| **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_/\_\_\_/\_\_\_\_ |
| **FOR OFFICE USE ONLY** |
| **Vaccine(s) Given (Circle)** | **#** | **Immunization & VIS Date Given/Offered** | **Patient Initials** | **Route & Site** | **Lot Number** | **Administered by:Initials** |
| **Hepatitis A (Hep A)** – >19yr90632 – V05.3 | 1 | 2 |  |  | IM R LAT DT |  |  |
| **Hepatitis B (Hep B) -** >20yr90746 – V05.3 | 13 | 2 |  |  | IM R LAT DT |  |  |
| **HPV4 –** 11 – 26yr90649 – V04.89 | 13 | 2 |  |  | IM R LAT DT |  |  |
| **Influenza (LAIV)** - 2-49yrs 90672 – V04.81 | 1 | 2 |  |  | IN - ½ dose ineach nostril |  |  |
| **Influenza** **(TIV)** – >3yr: 0.5cc90658 – V04.81 | 1 | 2 |  |  | IM R LAT DT |  |  |
| **IPV –** >18yr90713 – V04.0 | 13 | 24 |  |  | SQ IM R LAT LT TR DT |  |  |
| **JE/Ixiaro –** >17yr | 1 | 2 |  |  | IM R L AT DT |  |  |
| **MCV4 (Menactra)** – >19yr90734 – V03.9  | 1 |  |  |  | IM R LAT DT |  |  |
| **MPSV4 (Menomune)** - >55yr90733 – V03.9 | 1 |  |  |  | SQ R L RL TR |  |  |
| **MMR –** >19yr90707 – V06.4 | 1 | 2 |  |  | SQ R LLT TR |  |  |
| **PPSV23 (Pneumococcal) -** >50yr90732 - V03.82 | 13 | 24 |  |  | IM R LAT DT |  |  |
| **Rabies** – all ages90675 – V04.5 | 13 | 2 |  |  | IM R L AT DT |  |  |
| **Td** - >19yr 90714 – V06.5 | 13 | 2 |  |  | IM R LAT DT |  |  |
| **Tdap -** >19yr 90715 – V06.1 | 1 |  |  |  | IM R LAT DT |  |  |
| **Typhim Vi** – >2yr | 1 |  |  |  | IM R L AT DT |  |  |
| **Typhoid Oral –** >5yrs | 1 |  |  |  | ORAL |  |  |
| **Varicella** - > 1yr90716 – V05.4 | 1 | 2 |  |  |  SQ R LLT TR |  |  |
| **Twinrix (Hep A/B)** –>18yr90636 – V05.3 | 13 | 2 |  |  | IM R LAT DT |  |  |
| **Yellow Fever** - >9mo(Give YF questionnaire) | 1 |  |  |  | SQ R L LT TR |  |  |
| **Zostavax (shingles)** - > 60yr | 1 |  |  |  |  SQ R LLT TR |  |  |
| **Other:** |  |  |  |  |  |  |  |

Place patient sticker here

**Reviewing Provider:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Initials:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**