**** **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 Year  Phone 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)** – >19yr  90632 – V05.3 | | 1 | 2 |  |  | | IM R L  AT DT |  | | |  | |
| **Hepatitis B (Hep B) -** >20yr  90746 – V05.3 | | 1  3 | 2 |  |  | | IM R L  AT DT |  | | |  | |
| **HPV4 –** 11 – 26yr  90649 – V04.89 | | 1  3 | 2 |  |  | | IM R L  AT DT |  | | |  | |
| **Influenza (LAIV)** - 2-49yrs  90672 – V04.81 | | 1 | 2 |  |  | | IN - ½ dose in  each nostril |  | | |  | |
| **Influenza** **(TIV)** –  >3yr: 0.5cc  90658 – V04.81 | | 1 | 2 |  |  | | IM R L  AT DT |  | | |  | |
| **IPV –** >18yr  90713 – V04.0 | | 1  3 | 2  4 |  |  | | SQ IM R L  AT LT TR DT |  | | |  | |
| **JE/Ixiaro –** >17yr | | 1 | 2 |  |  | | IM R L  AT DT |  | | |  | |
| **MCV4 (Menactra)** – >19yr  90734 – V03.9 | | 1 |  |  |  | | IM R L  AT DT |  | | |  | |
| **MPSV4 (Menomune)** - >55yr  90733 – V03.9 | | 1 |  |  |  | | SQ R L  RL TR |  | | |  | |
| **MMR –** >19yr  90707 – V06.4 | | 1 | 2 |  |  | | SQ R L  LT TR |  | | |  | |
| **PPSV23 (Pneumococcal) -** >50yr  90732 - V03.82 | | 1  3 | 2  4 |  |  | | IM R L  AT DT |  | | |  | |
| **Rabies** – all ages  90675 – V04.5 | | 1  3 | 2 |  |  | | IM R L  AT DT |  | | |  | |
| **Td** - >19yr  90714 – V06.5 | | 1  3 | 2 |  |  | | IM R L  AT DT |  | | |  | |
| **Tdap -** >19yr  90715 – V06.1 | | 1 |  |  |  | | IM R L  AT DT |  | | |  | |
| **Typhim Vi** – >2yr | | 1 |  |  |  | | IM R L  AT DT |  | | |  | |
| **Typhoid Oral –** >5yrs | | 1 |  |  |  | | ORAL |  | | |  | |
| **Varicella** - > 1yr  90716 – V05.4 | | 1 | 2 |  |  | | SQ R L  LT TR |  | | |  | |
| **Twinrix (Hep A/B)** –>18yr  90636 – V05.3 | | 1  3 | 2 |  |  | | IM R L  AT DT |  | | |  | |
| **Yellow Fever** - >9mo  (Give YF questionnaire) | | 1 |  |  |  | | SQ R L  LT TR |  | | |  | |
| **Zostavax (shingles)** - > 60yr | | 1 |  |  |  | | SQ R L  LT TR |  | | |  | |
| **Other:** | |  |  |  |  | |  |  | | |  | |

Place patient sticker here

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