Immunization Consent Form

WF

For Staff Use Only

☐ **VFC**
☐ **SF**
☐ **Private**

Eligibility Code: _____

Patient Demographic Information

Patient Legal Name: _____
Last *First* *M.I.*

Preferred Name/Pronouns: _____
(If applicable)

Sex Assigned At BIRTH ☐ **M** ☐ **F**

DOB: _____ **AGE:** ____
mm dd yyyy

Gender Identity: _____
(Optional)

SSN: _____

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

City: _____ **State:** _____ **Zip:** _____

Maiden Name: _____
(If applicable)

Phone: _____

Physician: _____

Email: _____

Race: ☐ White ☐ American Indian ☐ Asian/Pacific Islander ☐ Hispanic ☐ Black ☐ Multiracial ☐Other

MSU Student? ☐ **Yes** **Please include permanent address below**

Permanent Address: _____ **City:** _____ **State:** ____ **Zip:** _____

PARENT INFORMATION/GUARDIAN: (Required for all patients under 18 years of age)

Parent/Guardian Name: _____ **Parent/Guardian DOB:** _____

Parent or Guardian SSN: _____

Payment Information

☐ **Insurance** ☐ **None/Self Pay** ☐ **Employer is paying/Name of Employer:** _____

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

Subscriber's Name: _____ DOB: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Acknowledgement and Consent

ALL PATIENTS or parents/guardians: Please check each box and sign/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 disease(s) and the vaccine(s). I have had a chance to ask questions which were answered to my satisfaction.

☐ I understand the benefits and risks of the vaccine(s) and request the vaccine(s) to the person named 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 disclosures.

☐ I consent to the shared 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, childcare 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 an extended period of time and will not 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, regardless of this designation.

OVERSEAS TRAVELERS ONLY

If you will be traveling for an extended period of time, who can we contact regarding a balance on your account?

Name: _____ Address: _____ Phone: _____

Signature: _____ **Date:** _____

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? **(DPT, DTaP vaccines)**	☐	Yes	☐	No
Taking Corticosteroids? **(MMR, Varicella, YF, LAIV, Shingles)**	☐	Yes	☐	No
Allergic to chicken eggs? (anaphylactic reaction: hives, swelling of mouth and throat, difficult breathing) **(Flu, YF)**	☐	Yes	☐	No
Allergic to yeast? (anaphylactic reaction: hives, swelling of mouth and throat, difficult breathing) **(HepB, 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, Menactra, Rotarix)**	☐	Yes	☐	No
Has or have other Allergies? List here: _____	☐	Yes	☐	No
Have active tuberculosis? **(MMR, Varicella, YF, LAIV, Shingles)**	☐	Yes	☐	No
Have ☐Cancer ☐Leukemia ☐Immune Problems **(MMR,OPV,Varicella,YF,Shingles)** Or other chronic disease? ☐Heart Disease ☐Kidney Disease ☐ Metabolic Disease, such as ☐Diabetes ☐Lung Disease ☐Asthma ☐Anemia ☐Other Blood Disorders	☐	Yes	☐	No
Living with someone who is being treated for cancer, has immune problems, or has another serious illness? **(Live vaccines)**	☐	Yes	☐	No
Had any live virus vaccine in the past 30 days? **(MMR, Varicella, YF, LAIV, Shingles)**	☐	Yes	☐	No
Have congenital or heredity immune problems? **(Live vaccines)**	☐	Yes	☐	No
Received blood products, transfusion, plasma, organ or stem cell transplant or been given a medicine called immune globulin during the past several months? **(MMR, Varicella, YF, LAIV, Shingles)**	☐	Yes	☐	No
Sick today, or have/had an acute illness with fever within the last twenty-four hours?	☐	Yes	☐	No
For Women: Is it possible that you are pregnant or may become pregnant in the next month?	☐	Yes	☐	No
For babies: is there a history of intussusception? **(Rotavirus)**	☐	Yes	☐	No

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Clinic Date: _____ **Nurse Signature:** _____ **Recall Date:** _____

Vaccine	Lot Number	Dose	Site	Vaccine	Lot Number	Dose	Site
DTaP		1 2 3 4 5		Pediarix/ Dtap/Ipv/Hepb		1 2 3	
Flu Shot		1 2		Pentacel/ Dtap/Ipv/Hib		1 2 3 4	
				Pneumovax		1 2	
Hep A		1 2		Prevnar-13		1 2 3 4	
Hep B		1 2 3		Jap. Enc.		1 2	
HIB		1 2 3 4		Rotateq		1 2 3	
HPV age 9-26		1 2 3		TB			
Rabies		1 2 3		Td		1 2 3 4 5 6	
IPV		1 2 3 4 5		TDaP			
Kinrix (Dtap/Ipv)		4 5		Twinrix HepA/B		1 2 3	
Meningococcal Meningitis/Menomune		1 2		Typhoid Oral Typhoid IM			
Meningococcal Meningitis/Menveo		1 2		Varicella Cpox		1 2	
MMR		1 2		Yellow Fever >9mos			
MMR/Proquad		1 2		Zostavax/Shingles age 50+			

TVL APT FEE: ☐Yes ☐No 1st 2nd 3rd #____ YC-CARD ONLY: _____ PRODUCT: Perm #_____ Ultra #_____ Saw (lg) #_____ Saw(sm) #_____

(Circle One) (Enter Number)