Vaccine Consent & Billing Form For Adults

PERSONAL INFORMATION

FIRST NAME	MIDDLE INITIAL	LAST NAME		

ADDRESS	CITY	STATE	ZIP

COUNTY	PHONE	GENDER	DATE OF BIRTH	AGE
		☐ Female ☐ Male		

ALLERGIES

SCREENING QUESTIONS

Are you sick today?	☐ Yes ☐ No
Do you have allergies to medications, food, a vaccine component, or latex?	☐ Yes ☐ No
Have you ever had a serious reaction after receiving a vaccination?	☐ Yes ☐ No
Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?	☐ Yes ☐ No
Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐ Yes ☐ No
In the past 3 months, have you taken medications that weaken your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease or psoriasis; or have you had radiation treatments?	☐ Yes ☐ No
Have you had a seizure or a brain or other nervous system problem?	☐ Yes ☐ No
During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐ Yes ☐ No
Have you received any vaccinations in the past 4 weeks?	☐ Yes ☐ No
For women: Are you breastfeeding, pregnant or is there a chance you could become pregnant during the next month?	☐ Yes ☐ No

Please remain in the pharmacy for 10 minutes following the vaccination. If you leave, you are doing so against medical advice.

Please check the vaccine that is being administered:

☐ Influenza	☐ Hepatitis A	☐ Td	☐ Zoster (Shingles)
☐ Pneumococcal	☐ Hepatitis B	☐ Tdap	☐ Other:
☐ HPV	☐ Meningococcal	☐ MMR	_____

I have read or have had explained to me the information in the *Vaccine Information Statement* about the vaccine that I am requesting. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request. **I understand that I may be held responsible for charges that are not covered by my insurance. I understand that if I do not provide the proper insurance information I may also be held responsible for charges.** For Medicare Recipients: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party that accepts assignment.

SIGNATURE OF PERSON TO RECEIVE VACCINE OR PERSON AUTHORIZED TO MAKE THE REQUEST (PARENT OR GUARDIAN) **DATE**

----------FOR CLINIC/OFFICE USE ONLY----------

IMMUNIZER	DATE OF IMMUNIZATION	VIS DATE

VACCINE	MEDICARE NUMBER	DIAGNOSIS CODE	INSURANCE
		Z23	

ID NUMBER	GROUP NUMBER	CASH