Georgia Department of Public Health
Effingham County
Health Department

VACCINE INFORMATION AND CONSENT FORM

Name: _____ _____ _____
First Middle Last

Address: _____ _____ _____ _____
Street City State Zip

Telephone: (_____)_____--_____ (_____)_____--_____
Home Other

Date of Birth: _____--_____--_____	Age:	**Gender:** ☐Male ☐ Female	**Primary Language:** ☐ English ☐Other _____	**Ethnicity: (check only 1)** ☐ Not Hispanic ☐ Hispanic ☐ Unknown

Race: (check only 1) ☐Asian/Polynesian ☐Black ☐Multiracial ☐White ☐Native Am/Alaskan ☐Unknown

Please answer the health questions below:	**Yes**	**No**	**Don't Know**
1. Are you sick today?			
2. Are you allergic to eggs, any vaccine, or any vaccine component?			
3. Have you ever had a serious reaction after receiving a vaccination?			
4. Have you received any vaccinations in the past four weeks?			
5. Are you a patient of hospice? (hospice patients not covered by Medicare)			
List allergies/medical conditions:			

Insurance/Payment Information (check only one)	
☐ Self-pay – Amount $	☐ Employer pays – Company Name:
☐ Medicaid # ☐ Medicare #	Supplement/Company Name:
☐ BlueCross/BlueShield ☐ State Health Benefit Plan ☐ Cigna ☐Aetna ☐ Coventry	
Insurance Group # or name:	Insurance Policy #:
Please include your insurance card to be copied and attached to this form.	

I have been given a copy and have read, or have had explained to me, the information in the Vaccine Information Statements for the vaccines indicated. I have had the chance to ask questions that were answered to my satisfaction. I believe that I understand the benefits and risks of the vaccines requested and ask that the vaccines indicated be given to me or the person named for whom I am authorized to make this request.

For Medicare Beneficiaries with Part B: I authorize the release of any medical or other information necessary to process this claim. I request payment of government benefits either to myself or the party who accepts assignment. I authorize payment of medical benefits to the undersigned physician or supplier for services described.

It is suggested that anyone getting a vaccine stay for 20 minutes after getting vaccinated before leaving.

_____ _____ **X**_____
Date **Print Name** **Patient/Guardian Signature**

OFFICE USE ONLY		**Record of Immunization**					**OFFICE USE ONLY**	
Vacc	**Manf**	**Lot #**	**Exp**	**Dsg**	**Rte**	**Ste**	**VIS**	**Nurse**