



VACCINE INFORMATION AND CONSENT FORM

Name: _____				
First	Middle	Last		
Address: _____				
Street	City	State	Zip	
Telephone: (____) _____ -- _____				
SSN _____				
Date of Birth: ____ -- ____ -- ____	Age: _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Other	Ethnicity: (check only 1) <input type="checkbox"/> Not Hispanic <input type="checkbox"/> Hispanic <input type="checkbox"/> Unknown
Race: (check only 1) <input type="checkbox"/> Asian/Polynesian <input type="checkbox"/> Black <input type="checkbox"/> Multiracial <input type="checkbox"/> White <input type="checkbox"/> Native Am/Alaskan <input type="checkbox"/> Unknown				

Please answer the health questions below:	Yes	No	Don't Know
1. Are you sick today?			
2. Are you allergic to anything including any food, any vaccine, any vaccine component, or latex?			
3. Have you ever had a serious reaction after receiving a vaccination?			
4. Have you received any vaccinations in the past four weeks?			
5. Do you, anyone you live with or take care of have a weakened immune system?			
6. Do you have any history of seizures or neurological conditions?			
7. Do you, anyone you live with or take care of take steroids, anti-cancer drugs or x-ray treatments?			
8. Is it possible that you are or may become pregnant in the next four weeks?			
9. In the last year have you received blood or plasma or been given immune globulin?			

Insurance/Payment Information (check only one)	
<input type="checkbox"/> Self-pay – Amount \$ _____	<input type="checkbox"/> Employer pays – Company Name: _____
<input type="checkbox"/> Medicaid # _____	<input type="checkbox"/> Medicare # _____ Other: _____
<input type="checkbox"/> BlueCross/BlueShield <input type="checkbox"/> Cigna <input type="checkbox"/> United Health <input type="checkbox"/> Aetna <input type="checkbox"/> Coventry <input type="checkbox"/> Humana <input type="checkbox"/> TRICARE Standard Only	
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

Date of Vaccination: _____