

Elkhorn Logan Valley Public Health Department

CLIENT VACCINE CONSENT FORM

Last Name	First Name	Middle Initial	Maiden Name	Date of Birth ____/____/____	Age
Address		City	State	Zip	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Phone (____) ____ - ____	E-Mail address		Name of Physician	

Insurance Status:

Private Insurance covers immunizations

Private Insurance does NOT cover immunizations

Heritage Health / Medicaid

American Indian / Alaska Native

No Insurance

For private insurance (policy holder information):

Policy Holder Name and Date of Birth:

Name: _____ Date of Birth: ____/____/____

Client Relationship to Policy Holder:

Self Spouse Child Other

Answer the Following Client Health Questions

Are you sick today?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had a serious reaction after receiving a vaccination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have allergies to medications, food, a vaccine component, or latex?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease, (e.g. diabetes) or blood disorders?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have cancer, leukemia, AIDS or any other immune system problem?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had a vaccine in the past four weeks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you take cortisone, prednisone, steroids, anticancer drugs, or had recent x-rays?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has Guillan-Barre syndrome occurred within six weeks of receipt of any prior vaccine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have a bleeding disorder such as hemophilia or thrombocytopenia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have an unstable neurological condition such as seizures, brain or nerve problems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
During the past year, have you received a transfusion of blood / blood products, or been given immune (gamma) globulin or an antiviral drug?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<u>For women only:</u> Are you pregnant or breastfeeding a child?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Consent to Vaccinate

I have read the Vaccine Information Statement(s) (VIS) given to me about the vaccine(s) the client is receiving today as noted below under "vaccines provided". I understand the vaccines given are based upon those recommended for the client's age, circumstances and/or available vaccine history. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) and their presently known side effects. There is no guarantee of immunity or that the client will not experience an adverse reaction to the vaccine(s). In the event of adverse side effects or that immunity does not occur, I hereby hold ELVPHD harmless for any and all liability to the extent permitted under the law. All vaccines administered by ELVPHD will be entered into NESIIS (Nebraska State Immunization Information System). If applicable, I permit these services to be submitted to insurance. If the insurance does not pay, I understand that I am responsible for payment. ELVPHD provides Privacy Practices upon request from the client and this consent is considered the offer to provide ELVPHD's Privacy Practices. I have had a chance to ask questions about the Privacy Practices, and those questions have been answered to my satisfaction. I authorize ELVPHD to release information from the client's medical record including, but not limited to, the following entities: client family/guardians/representatives requesting the immunization record, child care, school or work-related authorities to prove immunization status, medical providers, medical records, billing and insurance. I understand that this release will expire two years from the date of consent and that the release may be revoked at any time by notifying ELVPHD in writing. The revocation will be effective as of the date notified except to the extent action has already been taken. I authorize ELVPHD to photograph me and/or my child(ren) during the services provided and utilize the image(s) for publishing and/or distribution.

X _____

Signature of Patient or Patient's Representative Date

Printed Name: _____ Relationship to Client (if a child): _____

To be completed by staff:

- DTap
- Hep A
- Hep B
- Hib
- Other: _____
- HPV
- Infanrix
- Influenza
- IPV

Vaccines Provided:

- Kinrix
- Meningitis
- Meningitis B
- MMR
- Pediarix
- Pentacel
- PCV 13
- PPSV23
- Rotavirus
- Shingles
- Td/Tdap
- Varicella

To be completed by staff:

Manufacturer: (check which type)

Fluarix (Lot #4ZY53) – exp 6/30/2019 (Glaxo) – 0.5cc, IM

Fluarix (Lot #5T943) – exp 6/30/2019 (Glaxo) – 0.5cc, IM

Fluarix (Lot #JZ3B7) – exp 6/30/2019(Glaxo) – 0.5cc, IM

High-Dose Fluzone (Lot #UI977AB) – exp 3/9/2019 (Sanofi) – 0.5cc, IM

VFC FluLaval Quad (Lot #972F3) – exp 6/13/2019– 0.5cc, IM

Injection Site (circle):

Left Deltoid Right Deltoid

Other (specify): _____

Manufacturer: _____ **Lot #:** _____ **Exp Date:** _____

Injection Site (circle one): Left Deltoid Right Deltoid
Other (specify) _____

Dosage: 0.5cc **Route:** IM
Other (specify) _____

Manufacturer: _____ **Lot #:** _____ **Exp Date:** _____

Injection Site (circle one): Left Deltoid Right Deltoid
Other (specify) _____

Dosage: _____ **Route:** IM
Other (specify) _____

Manufacturer: _____ **Lot #:** _____ **Exp Date:** _____

Injection Site (circle one): Left Deltoid Right Deltoid
Other (specify) _____

Dosage: 0.5cc **Route:** IM
Other (specify) _____

Manufacturer: _____ **Lot #:** _____ **Exp Date:** _____

Injection Site (circle one): Left Deltoid Right Deltoid
Other (specify) _____

Dosage: 0.5cc **Route:** IM
Other (specify) _____

Manufacturer: _____ **Lot #:** _____ **Exp Date:** _____

Injection Site (circle one): Left Deltoid Right Deltoid
Other (specify) _____

Dosage: 0.5cc **Route:** IM
Other (specify) _____

_____ Signature of Vaccine Administrator	_____ Date of Vaccine Administration	For Private Pay Only: Amount Paid: \$ _____ <input type="checkbox"/> Cash <input type="checkbox"/> Check (# _____)
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