SKAMANIA COUNTY IMMUNIZATION CONSENT

PATIENT (PLEASE PRINT) LAST NAME:	FIRST NAME:	M.I:	BIRTH DATE:
PHYSICAL ADDRESS:	CITY:	STATE:	ZIP CODE:
MAILING ADDRESS: (IF DIFFERENT THEN ABOVE)	CITY:	STATE:	ZIP CODE:
PHONE NUMBER:	PRINTED NAME OF PARENT OR GUARDIAN:		
(PARENT OR GUARDIAN MUST AUTHORIZE IMMUNIZATION ON REVERSE SIDE FOR A PATIENT UNDER AGE 18)			

- Are you American Indian or an Alaskan Native? YES_____ NO_____

YES	NO	DON'T KNOW	PLEASE ANSWER EACH QUESTION BELOW
			Experienced fever, vomiting or diarrhea today?
			Received any other immunizations during the past month?
			Had allergies to medications, eggs, yeast, gelatin, other foods or chemicals?
			Had a serious reaction or allergy to a vaccine in the past?
			Had the chickenpox? Approximate date or age of disease: _____
			Had a seizure, changing neurological disorder, or Guillain-Barre syndrome?
			Ever had thrombocytopenia (decreased platelets/increase bleeding)?
			Received blood, plasma, or immune globulin in the past six months?
			Have a bleeding disorder or take medications that increase bleeding?
			Are you Pregnant or planning to be pregnant within the next month?
			Had history of thymus disease, thymectomy, or intussusceptions?
			Does the patient or anyone in the home have: cancer, an immune disorder, a Spleen removed, an organ transplant, or being treated with medications for Rheumatoid, psoriasis, or autoimmune disease, or medications that suppress the immune system?
			Is the patient or anyone at home HIV positive?

Please sign ONE payment method below (A OR B):

A: Bill My Insurance Carrier: _____ ID Number: _____

SIGNATURE_____ DATE_____

I authorize my insurance benefit to be paid directly to the provider. I authorize the provider or insurance company to release any information required for this claim.

B: Other: PLEASE STATE WHO WILL BE PAYING FOR THIS SERVICE

☐ **EMPLOYER:_____** **OR** ☐ **SELF PAY** **OR** ☐ **UNINSURED**

SIGNATURE_____ DATE_____

I have been offered an emailed or paper copy of the Vaccine Information Statement(s) (VIS) checked on the reverse side. I have read, had explained to me, and understand the information in the VIS(s). I understand the benefits & risks of the vaccines, and I ask that the vaccine(s) checked on the reverse side be given to me or to the person named above for whom I am authorized to make this request. I provide verbal consent for staff to complete and sign this form on my behalf for drive-up vaccination.

_____ _____

SIGNATURE OF PATIENT/GUARDIAN/STAFF **DATE**

CLINICAL USE ONLY:
VFC Status: ____Private insurance ____Uninsured ____Medicaid

___ Underinsured

Name_____

Age _____

√ VIS Given	Vaccine	Dose #	Manufacturer & Lot Number	Route/ & Site	Dose	Vaccine Information Statement (VIS)
	Diphtheria/Tetanus/Pertussis DTaP____ DT____ 2mo-6yrs	1,2,3, 4,5	GSK Sanofi	IM: _____	0.5 cc	Diphtheria, Tetanus & Pertussis 4/1/2020
	Haemophilus b Conjugate (HIB) 2mo- 4 yrs	1,2,3,4	Merck Sanofi	IM: ___	0.5 cc	Haemophilus b Conjugate 10/30/2019
	Hepatitis A State ____ Private ____ 2-18 yrs 19 + yrs	1,2	GSK Merck	IM: ____	0.5 cc	Hepatitis A 7/28/2020
	Hepatitis B State ___ Private ___ 0-18 yrs 19+	1,2,3	GSK Merck	IM: ____	0.5 cc	Hepatitis B 8/15/2019
	HPV State_____ Private____ 9-18 yrs 19-26 yrs	1,2,3	Merck	IM: ____	0.5 cc	HPV 10/30/2019
	Influenza State ____ Private ____ 6 mo-18 yrs 19+ yrs	1,2	Sanofi	IM: ____	0.25 cc 0.5 cc 0.2 cc	Influenza 8/15/2019
	Measles-Mumps-Rubella State _____ Private ____	1,2	Merck	SC: ___	0.5 cc	Measles, mumps, Rubella 8/15/2019
	Menactra State ____ Private ____ 11-18 yrs 19-55 yrs	1,2	Sanofi	IM: ____	0.5 cc	Meningococcal 8/15/2019
	Pediarix (DTaP + IPV + HepB) 2 mo- 6 yrs	1,2,3	GSK	IM: _____	0.5 cc	Diphtheria, Tetanus & Pertussis 02/24/2015 + Polio 07/20/2016 + Hepatitis B 07/20/2016
	Pneumococcal 2 yrs- Adult	1, 2	Merck	IM: ___	0.5 cc	Pneumococcal (PPSV) 10/30/2019
	Pneumococcal Conjugate PCV 13 2 mo-4 yrs	1,2,3,4	Wyeth	IM: ____	0.5 cc	Pneumococcal Conjugate 10/30/2019
	Polio Vaccine State___ Private____ 2-18 yrs 19+ yrs	1,2,3,4	Sanofi	SC: ____	0.5 cc	Polio 10/30/2019
	Rotavirus 6-32 weeks only (1st dose 6-12 weeks only)	1,2,3	Merck	Oral: ____		Rotavirus 10/30/2019
	Tetanus/Diphtheria, Pertussis Tdap____ Td____ State____ Private_____ 7-18yrs/11-18yrs 19+ yrs	1,2,3 4,5	GSK Sanofi	IM: _____	0.5 cc	Tetanus, Diphtheria 4/1/2020 Tetanus/Diphtheria, Pertussis 4/1/2020
	Varicella State___ Private ____ 2-18 yrs 19+ yrs	1,2	Merck	SC: ____	0.5 cc	Varicella 8/15/2019

_____ _____

SIGNATURE AND TITLE OF VACCINE ADMINISTRATOR **DATE**