Consent for Immunization of Adult

FOR ADMINISTRATIVE USE ONLY

Location: _____ PRIVATE _____ STATE _____
Date: _____ Cash _____ Check #_____

Nursing Signature: _____

□ TDaP LOT # _____, EXP date _____ Injection Site _____

□ Hepatitis A Dose 1, Dose 2 LOT # _____, EXP date _____ Injection Site _____

□ Hepatitis B Dose 1, Dose 2, Dose 3 LOT # _____, EXP date _____ Injection Site _____

□ Shingrix □ Pneumococcal 23/ Prevnar 13 LOT # _____, EXP date _____ Injection Site _____

□ Influenza LOT # _____, EXP date _____ Injection Site _____

PLEASE COMPLETE AND SIGN

Name: _____ DOB: _____ Sex: M or F
Race: _____
Address: _____ City/State: _____Zip:_____

Phone Number: Home: _____Work: _____ Cell: _____

Please circle: Wellcare Medicaid Peachstate Amerigroup BCBS BCBS Federal BCBS-SHBP
BCBS Open Access BCBS Open Access POS BCBS Board of Regents
Aetna HMO Aetna PPO Aetna Choice POS AetnaSelect **Medicare** MedicareAdvantageHMO
Coventry National MedicareAdvantra ElectChoice AetnaManagedChoice OpenAccessAetna
AetnaSelect CIP Mailhandler/Coventry
Policy # :_____ Effective Date: _____

*If your insurance is not listed, we cannot file it for you. You will have to pay out of pocket for your vaccines today. Please see the clerk for details and cost. Payment may be made by cash or check. Please make check payable to **HOUSTON COUNTY HEALTH DEPARTMENT**.

Please initial:

___I do hereby give my consent to receive the vaccine(s) indicated above. The vaccine(s) will be administered by a licensed nurse at my school/business. I understand that the vaccine I will receive is recommended by the Center for Disease Control (CDC) for the prevention of the disease indicated. I have received and read the Vaccine Information Statement for the indicated vaccine and understand the risks and benefits of vaccination. By signing below, I consent to vaccination and attest that the information I have provided is true and accurate.

___I acknowledge that I received a copy of the Notice of Privacy Practices for the North Central Health District (NCHD), which sets forth the ways in which my personal health information may be used or disclosed by the NCHD or the county health department, and outlines my rights with respect to such information.

___ I understand that the Houston County Health Department requires payment in full at the time of service if we are not filing one of the above mentioned insurance plans. Our office may verify benefits for the above insurance companies prior to providing services. However, we are unable to verify coverage during off-site campaigns. Denied claims, due to non coverage will be billed to the patient for payment by the patient. Insurance filed by our facility is not a guarantee of payment by the insurance provider. It is the patient's responsibility to read and understand their insurance benefits.

Please circle:

I have a serious allergy to eggs, egg proteins, gentamicin, latex, gelatin, arginine, yeast, or any vaccine. YES NO

I have had a serious reaction to a previous vaccine. YES NO

I have a history of Guillain-Barre' Syndrome, seizures, epilepsy, encephalopathy. YES NO

I have had a fever of 101 degrees or more in the past 24 hours. YES NO

A "YES" answer to any of the following questions means that you must consult your doctor and the shot CANNOT be given in the offsite clinic. Please address any concerns not addressed above with the nurse PRIOR to vaccination

SIGNATURE:_____**DATE:**_____