Adult Immunization Consent Form

Clinic Date: _____

A. Information about person receiving vaccine (Please print)

Patient's Name Last_____ First_____ Middle_____

Patient's Birth Date_____ Age _____ Gender Male Female Phone #_____

Patient's Address_____ City_____ Zip Code_____

Insurance Company: _____**Insurance Phone Number:** _____

Insurance Address:_____

Policy/ID Number: _____ **Group Number:** _____

Policy Holder Name: _____**Policy Holder DOB:** _____

Policy Holder Employer:_____

B. Vaccine Health Screening (circle Yes or No)

Please answer all questions about the patient who will be receiving the vaccine(s). Answers will determine whether the patient can be vaccinated at this time. **If you respond 'Yes' to any of the questions, please explain in the space provided below.**

Yes	No	1. Do you have any allergies to medication, foods, or any vaccines?
Yes	No	2. Have you had a serious reaction to a vaccine in the past?
Yes	No	3. Have you had a health problem with asthma, lung disease, heart disease, kidney disease, metabolic disease (i.e. diabetes), or a blood disorder?
Yes	No	4. Have you had a seizure, brain, or other nervous system problem, including Guillain-Barré Syndrome?
Yes	No	5. Do you have cancer, leukemia, AIDS, active tuberculosis or any other immune system problem?
Yes	No	6. Have you taken cortisone, prednisone, other steroids or anticancer drugs or had radiation treatments in the past three (3) months?
Yes	No	7. Have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug in the past year?
Yes	No	8. Are you pregnant or is there a chance you could become pregnant during the next month?
Yes	No	9. Have you received vaccinations in the past four (4) weeks?

Please explain any 'Yes' responses._____

Screening Reviewed by:_____

C. Eastern Idaho Public Health Insurance Liability Waiver:

The cost of a billable service is the responsibility of the client/guarantor. Regular monthly payments in any amount are accepted to keep accounts from going to a collection agency. For unpaid balances a payment plan can be arranged with the clerical staff. By signing, I consent to third party billing, including payment of government benefits to EIPH, and understand that services eligible for a sliding fee will be billed at 100% to third party payers.

Insurance (if applicable): As a courtesy, EIPH will bill your insurance for most immunization services; however, ***EIPH is not a preferred provider for all insurances***. It is recommended that you check with your health insurance regarding coverage. Client/guarantor will be billed for any remaining balances after insurance has been processed.

D. Consent to Vaccinate

I have been given a copy and I have read, or had explained to me, the information in the Vaccine Information Statement(s) for the all age appropriate vaccines indicated that could be given. I have had a chance to ask questions and fully understand the benefits and risks of each of the indicated vaccine and consent to receive any Advisory Committee on Immunization Practices (ACIP) recommended vaccine that they are due for.

Signature of Consent: _____ Date: _____

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Patient Name:_____Patient age:_____

OFFICE USE BELOW

E. To be completed by person administering vaccine

Vaccination Date:			**Payer Source**	**Codes**	
EIPH Office: 1250 Hollipark Drive Idaho Falls, ID 83401 (208)533-3235			**Insurance Medicare** **State Supplied Adult**	**90471 Flu only 90471 G0008** **90472 90473**	
Vaccine		**Lot Number**	**Provider Name**	**Site**	**Route**
90686	**Fluarix (Quad)**			Left or Right Deltoid: Arm: Leg	IM
90688	**Fluzone (Quad) MDV**			Left or Right Deltoid: Arm: Leg	IM
90688	**Flulaval (Quad) MDV**			Left or Right Deltoid: Arm: Leg	IM
90674	**Flucelvax (Quad)**			Left or Right Deltoid: Arm: Leg	IM
90662	**HD Flu**			Left or Right Deltoid: Arm: Leg	IM
90715	**Tdap**			Left or Right Deltoid: Arm: Leg	IM
90686	**Fluzone (Quad) (317)**			Left or Right Deltoid: Arm: Leg	IM
90715	**Tdap (317)**			Left or Right Deltoid: Arm: Leg	IM
	Other			Left or Right Deltoid: Arm: Leg	SQ/IM
	Other			Left or Right Deltoid: Arm: Leg	SQ/IM

Screening Reviewed and Education Provided by: _____

Checked In ☐ Scanned ☐ SuperBilled ☐ Checked out ☐ Historical ☐

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