Immunization Visit

Acknowledgement, Consent and Authorization

PLEASE ANSWER THE QUESTIONS BELOW (Place an "X" under "YES" or "NO")	YES	NO
Are you sick today?		
Do you have allergies or reactions to any medications, foods or vaccines? (For example eggs, chicken, gelatin, Thimerosal (contact solution), myosin, latex, etc.) Please list		
Are you on anticoagulation medication? (For example warfarin, Coumadin or other blood thinner?)		
Have you had a seizure, brain or nervous system problem?		
Do you have a long term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (diabetes), anemia or other blood disorder?		
Do you have cancer, AIDS or any other immune system disorder?		
Do you take cortisone, prednisone, other steroids or anticancer drugs or have you had radiation treatments?		
During the past year have you received a transfusion of blood or blood products or been given a medicine called immune (gamma) globulin?		
Have you received a vaccination in the past 4 weeks?		
For women: Are you pregnant or nursing? Could you become pregnant in the next month?		
Do you have allergies or reactions to Neomycin?		

If you answered "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked.

VACCINE TO BE ADMINISTERED

☐ Td ☐ DTaP ☐ Tdap ☐ Menactra ☐ Hepatitis B ☐ Hepatitis A ☐ Pneumovax ☐ Influenza ☐ MMR ☐ Polio
☐ Zostavax ☐ H1N1 Inactivated vaccine ☐ H1N1 Live Intranasal vaccine

VACCINE INFORMATION STATEMENT

I acknowledge that I have been given a copy and have had an opportunity to read the information contained in the:
☐ Vaccine Information Statement(s) (fact sheet). I understand the benefits and risks of the vaccine(s).

CONSENT TO TREATMENT

I understand that vaccine(s) will be given by a licensed practitioner. / agree to *ask any questions about the vaccine(s) before they are administered.* I request that the vaccine(s) be given to me, or to the minor named below for whom I attest that I am the child's parent, authorized representative, or legal guardian and may provide effective consent for this immunization.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

I authorize _____ to use or release my health information: to other healthcare providers and their staff for treatment purposes; to third party payers and other third parties, as necessary, for _____ to obtain payment for services I have received; or for _____'s healthcare operations (such as administration and quality assurance). I further agree that _____ may request and use my prescription medication history as follows: from other healthcare providers or third party pharmacy benefit payers for treatment purposes.

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I understand that I am responsible for paying the cost of any services at the time services are provided and that, unless _____ has an agreement with my health plan or insurer and the services are covered under my plan, _____ is not responsible for obtaining reimbursement on my behalf, or for assisting me in obtaining reimbursement from any source. If _____ seeks reimbursement for services provided on my behalf, I understand that I am responsible for paying any co-payment or deductible amount at the time of service. If my health plan or insurer does not pay all remaining amounts due, I will be responsible for making payment in full to _____ for any and all services.

By signing below, I confirm my understanding of the above information and my consent to the above disclosures.

Patient Name (Please Print) **Birth Date** **Phone**

Address **City** **State** **Zip** **Country**

Signature X **Date**

If signed by anyone other than the patient, check box that describes relationship to patient:

☐ Parent ☐ Guardian ☐ Healthcare agent ☐ Other (please see _____ practitioner)

Notice of Privacy Practices (Please check only one box)

☐ I acknowledge that I have received the _____ Notice of Privacy Practices.

☐ I decline to accept the _____ Notice of Privacy Practices. Please initial _____ and provide the reason for refusal to accept the Notice of Privacy Practices.