Routine Vaccine Administration Questionnaire and Consent

Name: _____ **Client Number: #** _____
Date of Birth: _____-_____-_____ Age: _____ Male / Female
Responsible Person: _____ e-mail: _____
Address: _____ Telephone: _____
City: _____ State: _____ Zip Code: _____ Hispanic/Latino Yes / No

Race(s): Asian - Black - Indigenous American - Pacific Islander - White - Other: _____

HEALTH INSURANCE INFORMATION ☐ I do not have medical insurance.

Name of Card Holder: _____ DOB: _____-_____-_____ Male / Female
Insurance Company: _____ Member ID # _____ Group # _____
Insurance Company Address: _____
City: _____ State: _____ Zip Code: _____

PLEASE CIRCLE YOUR ANSWERS

1. Feeling sick today? No / Yes / Don't know
2. Have you received any vaccinations in the past 4 weeks? No / Yes / Don't know
3. Do you have any allergies to medications, food, a vaccine component, or latex? No / Yes / Don't know
4. Have you ever had a severe allergic reaction after receiving a vaccination? No / Yes / Don't know
5. Are you on a long-term aspirin therapy, blood thinner or have a blood disorder? No / Yes / Don't know
6. Have you had a seizure, or other nervous system problem? No / Yes / Don't know
7. Do you have cancer, HIV/AIDS, or any other immune system problem? No / Yes / Don't know
8. Do you have any long-term health problems with your heart, lung, kidney, liver, metabolic disease (e.g., diabetes), asthma or blood disorder? No / Yes / Don't know
9. In the past 3 months, have you taken medications that weaken the immune system, such as a cortisone, prednisone, other steroids, or anticancer drugs; or had radiation treatments? No / Yes / Don't know
10. In the past year, have you received a transfusion of blood products, or been given immune (gamma) globulin or an antiviral drug? No / Yes / Don't know
11. Do you live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation? No / Yes / Don't know
12. Have you ever had Guillain-Barre syndrome? No / Yes / Don't know
13. **WOMEN ONLY:** Are you pregnant or could become pregnant in the next 3 months? No / Yes / Don't know

I have reviewed and answered the questions above, to the best of my ability. I have reviewed the Vaccine Information Statement(s). I have voiced my questions and concerns. I am satisfied with the answers. I understand the benefits and risks of the recommended vaccine(s). I understand that it is my responsibility to provide up to date information on my medical

status and that providing incorrect information can be dangerous health-wise. I authorize the health care staff to perform the necessary health care services, today. I am aware that Southwest District Health enters all immunization records into the Idaho Immunization Reminder System (IRIS). I may opt out of IRIS at any time by contacting the Idaho Immunization Program. I understand that I can review the HIPAA Disclosure Form and that a copy can be provided to me at my request.

Payment is expected at the time of service. SWDH will bill your medical insurance company; You will be responsible for any remaining balance. For uninsured children, ages 18 and younger, an administration fee of $20.00 per vaccine will be charged, not to exceed $60.00 per visit.

By signing below, you are agreeing for the recommended vaccine(s) to be administered.

☐ COVID/Pfizer	☐ Flu	☐ Dtap	☐ Hep A	☐ Hep B	☐ HIB	☐ HPV
☐ MCV4	☐ Men B	☐ MMR	☐ Pneumococcal		☐ Polio	☐ Rabies
☐ RSV	☐ Rotavirus	☐ Tdap	☐ Varicella	☐ VZV/RZV – Shingles		

I declare under penalty of perjury under the laws of this state that the foregoing information is true and correct.

Patient/Parent/Guardian Signature: _____ **Today's Date:** _____-_____-_____

FOR CLINIC USE **INSURANCE NAME:** _____

☐ Adult Private (CP) ☐ Adult Uninsured (317) ☐ VFC Eligible (Child 0 to 18)

☐ Client/Parent/Guardian has been counseled, and questions have been answered regarding the following vaccines to be administered today. **VIS Statement(s) / Fact Sheet Made Available** ☐

☐ COVID/Pfizer	☐ Flu	☐ Dtap	☐ Hep A	☐ Hep B	☐ HIB	☐ HPV
☐ MCV4	☐ Men B	☐ MMR	☐ Pneumococcal		☐ Polio	☐ Rabies
☐ RSV	☐ Rotavirus	☐ Tdap	☐ Varicella	☐ VZV/RZV – Shingles		

Final Screener: _____ **Vaccinator:** _____ **Vaccination Date:** _____-_____-_____

Clinic Site: Caldwell Emmett Payette Weiser Other: _____

NOTES & Lot Stickers: _____