Immunization Consent Form

HEALTHY GALLATIN

For Staff Use Only

☐ VFC ☐ SF ☐ Private

Eligibility Code: _____

Patient Demographic Information

Patient Legal Name: _____
Last *First* *M.I.*

Preferred Name/Pronouns: _____
(If applicable)

Sex Assigned At Birth ☐ M ☐ F

DOB: _____ **AGE:** _____
mm dd yyyy

Gender Identity: _____
(Optional)

SSN _____

Mailing Address: _____ **Apt #:** _____

City: _____ **State:** _____ **Zip:** _____

Maiden Name: _____
(If applicable)

Phone: (_____) _____

Physician: _____

Email: _____
May we email you billing information ☐ **yes** ☐ **no**

Race: ☐ White ☐ American Indian ☐ Asian/Pacific Islander ☐ Hispanic ☐ Black ☐ Multiracial ☐Other

Language: ☐ English ☐ Español ☐ Other _____

If -MSU Student? - Please include permanent address below
Permanent Address: _____ City: _____ State: _____ Zip: _____

PARENT INFORMATION/GUARDIAN: (Required for all patients under 18 years of age)

Parent/Guardian Name: _____ **Parent/Guardian DOB:** _____

Parent or Guardian Last 4 of SSN: _____ **Relationship to Patient:** _____

Payment Information

☐ Insurance ☐ None/Self Pay ☐ Employer is paying/Name of Employer: _____

Name of Insurance: _____ ID#: _____ Group#: _____

Subscriber's Name: _____ DOB: _____ Relationship to Patient: _____
Address: _____ City: _____ State: _____ Zip: _____

Acknowledgement and Consent 1-6

Overseas Travelers Only

☐ I understand that if I am traveling for an extended (more than I month) period of time, I must designate a responsible party to pay any unpaid balance. I understand that I still maintain full responsibility for the payment of the bill, regardless of this designation.
My contact person:
Name: _____ Address: _____ Phone: _____

ALL PATIENTS or parents/guardians: Please check each box and sign/date the signature box below.

☐ 1. I have read or have had explained to me the information contained in the **Vaccine Information Statement(s)** about the disease(s) and the vaccine(s). I have had a chance to ask questions which were answered to my satisfaction.

☐ 2. I understand the benefits and risks of the vaccine(s) and request the vaccine(s) to the person named above for whom I am authorized to make this request.

☐ 3. I have received and reviewed the Notice of Privacy Practices, which provides a description of information uses and disclosures.

☐ 4. I consent to the shared use of demographic information and authorize my immunization records to be recorded into the **State of Montana Immunization Registry f**or immunization health purposes and that it may be released to health care providers, childcare providers and schools across the state that may provide continuing immunization services. I understand that I can revoke this authorization and have my record removed at any time by contacting my local county health department.

☐ 5. I authorize payment of medical benefits to this county health department for services rendered. I understand that the patient or parent/guardian is responsible for any unpaid balances. I understand that any unpaid balance may be sent to a collections agency.

☐ 6. I understand that the standing orders under which the GCCHD administers vaccines recommends that all individuals receiving injections or TB tests remain under observation for 15 min after procedures. This is a safety precaution in case of fainting or allergic reactions: Please choose one option by initialing agree or decline.

Initial _____ **I AGREE to wait 15 minutes** _____ **I DECLINE to wait 15 minutes**

Signature _____ _____
If you are unable to electronically sign here, you can manually sign at time of service.

PLEASE READ CAREFULLY AND CHECK YES OR NO. THE NURSE WILL DISCUSS ANY YES RESPONSES WITH YOU.

IS THE PERSON RECEIVING THE IMMUNIZATIONS:

Sick today, or have/had an acute illness with fever within the last twenty-four hours?	☐	No	☐	Yes
Taking any medications? Please list: _____	☐	No	☐	Yes
Have or had convulsions, seizures, Guillain-Barre Syndrome, or had previous serious vaccine reactions? **(DTaP, TDaP, Flu)**	☐	No	☐	Yes
Taking Corticosteroids? **(Live Vaccines)**	☐	No	☐	Yes
Do you have allergies to medications, food, vaccine component, or latex? **(See Package Insert)**	☐	No	☐	Yes
Have ☐Cancer ☐Leukemia ☐Immune Problems? **(Live Vaccines)**	☐	No	☐	Yes
Other chronic diseases? ☐Heart Disease ☐Kidney Disease ☐ Metabolic Disease, such as ☐Diabetes ☐Lung Disease ☐Asthma ☐Anemia ☐Other Blood Disorders **(Live Vaccines)**	☐	No	☐	Yes
Had any live virus vaccine in the past 30 days? **(Live Vaccines)**	☐	No	☐	Yes
Received blood products, transfusion, plasma, organ or stem cell transplant or been given a medicine called immune globulin during the past year? **(Live Vaccines)**	☐	No	☐	Yes
For Women: Is it possible that you are pregnant or may become pregnant in the next month?	☐	No	☐	Yes
For babies: is there a history of intussusception? **(Rotavirus)**	☐	No	☐	Yes

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Clinic Date: _____ Nurse Signature: _____ Recall Date:

Vaccine	Lot Number	Dose	Site	Vaccine	Lot Number	Dose	Site
DTaP		1 2 3 4 5		Pediarix/ Dtap/Ipv/Hepb		1 2 3	
Flu Shot		1 2		Prevnar 20 PCV20		1	
Hep A		1 2		Pneumovax PPSV23		1 2	
Hep B		1 2 3		Prevnar 13 PCV13		1 2 3 4	
HIB		1 2 3 4		Rabies		1 2 3	
HPV age 9-26		1 2 3		Rotateq		1 2 3	
IPV		1 2 3 4 5		RSV (Arexvy)		1	
Jap. Enc.		1 2		Shingrix/Shingles age 50+or 19-49 w RX		1 2	
Jynneos/ MP SP		1 2		TB			
Kinrix (Dtap/Ipv)		4 5		TicoVac		1 2 3	
Meningococcal Meningitis B		1 2		Td		1 2 3 4 5 6	
Meningococcal Meningitis/Menveo		1 2		TDaP			
MMR		1 2		Twinrix HepA/B		1 2 3	
MMR/Proquad		1 2		Oral Typhoid Typhoid IM			
Vaxelis Dtap/Ipv/Hib/HepB		1 2 3		Variella Cpox		1 2	
				Yellow Fever >9mos			

Comments: