Adult Vaccination

MINERAL COUNTY
Health Department

Patient Information

Patient's Legal Name:		
Date of Birth:	**Age:**	**Gender:**
Mailing Address:		
Phone: Home:		Cell:

Patient Insurance Information

Select most appropriate form of insurance:				
None ☐	**Self-Pay** ☐	**Private** ☐	**Photo taken** ☐	
Insurance Info:	Name of Insurance:			
	ID:	Group:		
Subscriber Info:	Name:	DOB:		
	Relationship to patient:	Employer:		

Immunization(s) Requested

Please circle Yes or No to indicate desired vaccine(s)

Tdap	**Hep B**	**Hepatitis A**	
Yes No	Yes No	Yes No	

Health Information

The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

		Yes	No	Don't Know
1.	Is the person to be vaccinated feeling sick today?			
2.	Does the person to be vaccinated have allergies to medications, food, latex or any vaccine?			
3.	Has the person to be vaccinated had a serious reaction to a vaccine in the past?			
4.	Has the person to be vaccinated, a sibling or a parent had a seizure; has the person had brain or other nervous system problems?			
5.	Is the person to be vaccinated pregnant or is there a chance she could become pregnant during the next month?			

Acknowledgement and Consent

	Initials
I have read or have had explained to me the information contained in the Vaccine Information Statement about the disease and the vaccine. I have had a chance to ask questions which were answered to my satisfaction.	
I understand the benefits and risks of the vaccine and request the vaccine to be given.	
I have received, if requested, the Notice of Privacy Practices, which provides a description of information, uses and disclosures.	
I consent to the shared use of demographic information and authorize my immunization records to be recorded into the State of Montana Immunization Registry for immunization health purposes and that it may be released to health care providers. I understand that I can revoke this authorization and have my record removed at any time by contacting my local county health department.	
I authorize payment of medical benefits to this county health department for services rendered. I understand that the patient or responsible party is responsible for any unpaid balances.	

Patient Signature: _____ **Date:** _____

Health Department Section Only

Form reviewed by:	Date:
Vaccine Type: **Tdap**	Manufacturer:
Lot Number	Injection Site:
VIS Date:	Signature/title administrator:
Vaccine Type: **Hep B**	Manufacturer:
Lot Number	Injection Site:
VIS Date:	Signature/title administrator:
Vaccine Type: **Hep A**	Manufacturer:
Lot Number	Injection Site:
VIS Date:	Signature/title administrator:

Notes:

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