Delaware General Health District

ADULT VACCINE CONSENT FORM (PLEASE PRINT)

PATIENT LAST NAME:_____ FIRST NAME:_____ MI:____
Preferred Name:_____Maiden Name:_____
BIRTHDATE:_____(MM/DD/YYYY) AGE:_____RACE:_____SEX: (circle one) M F
STREET ADDRESS:_____CITY_____COUNTY_____
STATE:_____ ZIP CODE_____ PHONE NUMBER ( )_____ HOME CELL WORK

The clinic will keep this form for 10 years. It will include information on what vaccine(s) were given, when the vaccine(s)/tooth varnish were provided, the name of the company that made the vaccine(s), and the vaccine's lot number. Also, on record will be the name and address of where the vaccine(s) were given, name & title of the Nurse who gave the vaccine(s), and the publication date of your Vaccine Information Statement(s).

"**I** have read or have had explained to me the information in the **Vaccine Information Statement**(s) for the immunization(s) given and/or Tooth Varnish information today. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of these vaccines and ask that the vaccine(s) requested be given to me or to the person named below for whom I am authorized to make this request.

I understand that this information will be released to a state-wide **Immunization Registry** for the purpose of immunization tracking, recall and recording, unless I request otherwise.

I have received the DGHD **Notice of Privacy Practices** regarding the uses and disclosures of the health information for me and/or my child. **I** authorize **my insurance company** listed below to assign the amount payable directly to DGHD.

I understand that I am financially responsible for all the charges that are not covered under my private insurance plan. I acknowledge that any co-payment is due and payable on the date services are received."

For no insurance please complete to request discounted services:

CASH Pay SERVICES **"I state that there are_____ number of people living in my household and the combined household income is $_____ per WEEK / MONTH / YEAR" (circle one)**

Witness Signature (Receptionist or Nurse)_____Date_____

Patient Name (please print)_____

Patient Signature_____**Date**_____

Primary Insurance (Name of Company)_____ **MEMBER ID#**_____

Name of Primary Insured:_____**Relationship to Patient:**_____**Co-Pay/Co-Insurance amount: $**_____

Address of Primary Insured (if different from Patient**):** _____
Street City State Zip

Phone number of Insured: ( )_____

Secondary Insurance (Name of Company)_____ **MEMBER ID#**_____

Name of Primary Insured:_____**Relationship to Patient:**_____**Co-Pay/Co-Insurance amount: $**_____

Address of Secondary Insured (if different from Patient**):**_____
Street City State Zip

Phone number of Insured (**)**_____

Responsible Party (PRINT) Name:_____
Address: _____City:_____ State:_____Zip:_____
Phone Number: ( )_____ Home Cell Work (circle one)

OFFICE USE: **Insurance Pay_____ Cash Pay_____ MERCK_____ Americares_____ State_____ (Insurance Verified_____)**
Adult Medicaid_____ Other_____ _____IMPACT SIIS

Vaccine Administration Record

Client Return Date_____

DGHD 3 W. Winter St., Delaware, OH/Other_____Mon Tues Wed Thur Fri Sat_____AM_____PM_____4:30-6:30

VACCINE	DOSE #	MFG	LOT#	SITE	VIS Provided	SCREENED/ COUNSELED	SIGNATURE TITLE	DATE
GARDASIL 90649 private		MERCK		LD RD IM	05/17/13	Y N		
HEP A 90632 private state		GSK/ MERCK		LD RD IM	10/25/11	Y N		
HEP B 90746 private state		GSK/ MERCK		LD RD IM	02/02/12	Y N		
MENINGOCOCCAL private 90734		SP		LD RD IM	10/14/11	Y N		
MMR private 90707		MERCK		LA RA SQ	04/20/12	Y N		
PNEUMOCOCCAL private state 90732		MERCK		LD RD IM	10/16/09	Y N		
PREVNAR-13 90670		WYETH/ PFIZER		LD RD IM	02/27/13	Y N		
POLIO 90713		SP		LD RD SQ IM	11/08/11	Y N		
RABIES private 90675		SP		LD RD IM	10/06/09	Y N		
SHINGLES private 90736		MERCK		LA RA SQ	10/06/09	Y N		
TDAP 90715 private state americares		SP GSK		LD RD IM	05/09/13	Y N		
TD state 90714		SP		LD RD IM	2/4/2014	Y N		
TWINRIX state 90636		GSK		LD RD IM	10/25/11 02/02/12	Y N		
VARICELLA 90716		MERCK		LVL RVL LA RA SQ	03/13/08	Y N		
Nursing Assessment 99211	**Notes:** ☐ Reviewed medical history and contraindications, addressed all questions and/or concerns.							

CHOLESTEROL	CHOLESTECH	FINGERSTICK	HbA1C	HEMOGLOBIN
82465	80061QW	36416	83037	85018

Diluent