Adult Immunizations (19yrs and older)

Registered: _____
Scanned: _____
EZ Imm Doc: _____
ICARE: _____

SELF PAY
317 ADULT
MEDICARE
MEDICAID
PRIVATE

Last Name _____ **First**_____ **MI**_____

Date of Birth M: _____D:_____Y:_____ **Age** _____ **Male** **Female** **Other**

Street Address_____ **Phone**_____

City _____ **Zip** _____ **PID/MRN** _____

Race: _____ **Ethnicity: Hispanic or Latino** **Not Hispanic or Latino** **Other**

Select	Vaccine	Lot#	Site	Nurse Date/Time
	Hep A			
	Hep B			
	HIB			
	HPV			
	Japanese Encephalitis (Special Order)			
	Meningococcal			
	Meningococcal B			
	MMR II			
	Pneumococcal			
	Polio			
	TdaP			
	Twinrix (Hep A – Hep B)			
	Typhoid			
	Varicella			
	Yellow Fever (Special Order)			
	Zoster (shingles)			
	(RSV) AREXVY ABRYSVO			
	Influenza			
	High Dose Influenza (>65)			
	Pfizer			
	Novavax			

I voluntary consent to the treatment by Adams County Health Department. I understand the benefits, the risks of the vaccine(s) and ask the vaccine(s) stated above be given to me or the person above who I am authorized to make this request.

I understand that the ACHD is authorized to use the information gained during treatment to bill me or any other potential sources of reimbursement, such as government programs in which I am enrolled or qualified for services. Also, by signing I acknowledge that I am responsible for any remaining balance or co-pays that the insurance provided does not cover.

By signing below, I acknowledge that I was offered a copy of ACHD's Privacy Practices. The Notice describes how my health information may be used or disclosed. I am aware that the Notice may be changed at any time and that I may obtain a revised copy of the Notice by contacting the ACHD Privacy Officer or by requesting one at ACHD.

- ☐ **I request a hard copy of ACHD's Privacy Practices**
- ☐ **I would like to speak to someone regarding financial assistance for immunization costs or low-cost labs**

Signature: _____**Date:** _____

_____ _____

Printed Name if not the patient **Relationship to the patient**

For patients: 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.

Screening Questions	**Yes**	**No**	**Unsure**
Are you sick today?			
Do you have allergies to medications, food, a vaccine component, latex, eggs or chicken protein, sorbitol, or gelatin? Describe: _____			
Have you ever had a serious reaction after receiving a vaccination? Describe: _____			
Do you have a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Are you on long-term aspirin therapy? Describe: _____			
Do you have cancer, leukemia, HIV/AIDS, or any other illness that may affect your immune system? Or had cancer in the past? Describe: _____			
Do you have a parent, brother, or sister with an immune system problem?			
In the past year, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had chemotherapy or radiation treatments? Describe: _____			
Have you had a seizure or a brain or other nervous system problem?			
During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?			
For women: Are you pregnant or is there a chance you could become pregnant during the next month? Are you breastfeeding?			
Have you received any vaccinations in the past 4 weeks?			
Have you ever had Guillain-Barre Syndrome?			
ANSWER BELOW QUESTIONS FOR <u>YELLOW FEVER VACCINE ONLY</u>	**Yes**	**No**	**Unsure**
Have you been told that you may have a problem with your Thymus Gland? (Includes myasthenia gravis or a thyoma?			
Have you had open chest surgery?			
Have you had an operation to remove your thymus gland for any reason, including during cardiac surgery?			
Do you have a family member (blood relative) that has had a serious reaction to a yellow fever vaccine?			

Original 3/22, 6/22, 7/22, 9/22. 11/22, 01/23, 4/23, 08/23, 10/23, 8/25