IMMUNIZATION CONSENT AND RECORD

CLINIC SITE_____ DATE_____

Complete all highlighted sections

PATIENT AND INSURANCE/PAYMENT INFORMATION

NAME _____ DATE OF BIRTH_____ SEX (M)_____(F)_____

ADDRESS _____ APT _____

CITY _____ STATE _____ ZIP _____

PHONE (1) _____ (2) _____ LAST 4 DIGITS of SOCIAL SECURITY NUMBER_____

PRIMARY INSURANCE_____

ID #_____ GROUP #_____

SECONDARYINSURANCE_____

ID #_____ GROUP #_____

Other Payment

Cash _____ Check_____ Credit Card_____

PATIENT SCREENING 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.

	Yes	No	Don't Know	Comments:
INFLUENZA ONLY				
1. Are you sick today?				
2. Do you have allergies to medications, egg, vaccines, or latex?				
3. Have you ever had a serious reaction after receiving a vaccine?				
4. Have you had a seizure, a brain or nervous system problem or Guillain-Barre Syndrome?				
5. Have you received a vaccine in the last 4 weeks?				
OTHER IMMUNIZATIONS				
6. For women: Are you pregnant or is there a chance you could become pregnant during the next month?				
7. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease, anemia or other blood disorder?				
8. Do you or anyone living in your household have cancer, leukemia, HIV/AIDS or any other immune system problem?				
9. Do you have any problems with your immune system or take medications which affect your immune system?				
10. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?				

(**PATIENT**) Questions answered by: _____ Date _____

(**VACCINE ADMINISTRATOR**) Responses Reviewed by: _____ Date _____

Contraindications present? Yes/No If Yes, explain:

PATIENT CONSENT

- I have had a chance to ask questions and they were answered to my satisfaction. I believe I understand the benefits and the risks and ask that the vaccine or injection be given to me or to the person named for whom I am authorized to make this request.
- I have received a copy of the Vaccine Information Statement (VIS) for the vaccine that I will receive today. I have read or have had explained to me the information provided to me regarding the vaccines I will be receiving. I understand that I will need additional doses of the Hepatitis, Chicken Pox, Meningococcal B and/or Human Papilloma vaccines for long term protection.

  __ Influenza (*One dose*)

  __Hepatitis A and Hepatitis B Combo- Twinrix *(Two additional doses required at one and six months)*

  __ Hepatitis A Pediatric- Havrix 720ELU/ml (*One additional dose required at six to twelve months later*)

  __ Hepatitis A Adult- VAQTA *(One additional dose required six to eighteen months later)*

  __ Hepatitis B Pediatric- Energix-B 10mcg/0.5ml *(Two additional doses required at one month & six month later)*

  __ Hepatitis B Adult- Energix-B 20mcg/1.0ml *(Two additional doses required at one month and six months)*

  __ Human Papilloma (HPV)- Gardasil 9 *(One/Two additional doses required depending on age)*

  __ Measles, Mumps, Rubella- MMR II *(One dose)*

  __ Meningococcal ACWY- Menveo *(One dose)*

  __ Meningococcal B- Bexsero *(One additional dose required at two months)*

  __ Pneumonia conjugate (PCV13) - Prevnar 13 (*One dose*)

  __ Pneumonia polysaccharide (PPSV23) - Pneumovax 23 (*One dose*)

  __ Shingles- Shingrix (*One additional dose required two to six months later)*

  __ Tetanus, Diphtheria (Td) *(One dose)*

  __ Tetanus, Diphtheria, Pertussis (Tdap)- Boostrix *(One dose)*

  __ Chicken Pox (Varicella)- Varivax *(One additional dose at one month)*

  __ Other Vaccine_____
- I have received a copy of the Notice of Privacy Practices.
- Financial Responsibility:

  By my signature below, I acknowledge that I have received the vaccine as indicated and I authorize my provider to bill and collect from my insurance for the vaccine and related administration fees. I understand that this authorization does not release me from any financial responsibilities (co-payments or deductibles) required under my plan. I have been notified that my insurance may deny payment entirely or partially for the vaccine or injection. If my insurance denies payment for the entire amount or for a partial amount, I agree to be personally and fully responsible for payment.

Signature: _____ Date: _____

(To Be Completed By Vaccine Administrator)

VACCINE(S) ADMINISTERED

Codes for Vaccine

_____ 90688 Flulaval- Quadrivalent (age 3+)

_____ 90653 Fluad- Trivalent HD Flu (ages 65+)

_____ 90672 FluMist – Quadrivalent (ages 2-49)

_____ 90686 Fluarix – Quad. Pres Free (Egg-Based) (age 6 months+)

_____ 90661 Flucelvax - Quad Pres & Egg Free (ages 18+)

_____ 90636 Twinrix (Combined Hep A & Hep B)

_____ 90633 Havrix 720ELU/0.5ml (Hepatitis A Pediatrics)

_____ 90632 Vaqta (Hepatitis A Adults)

_____ 90744 Energix-B 10mccg/0.5 (Hepatitis B Pediatrics)

_____ 90746 Energix- B 20mccg/1.0ml (Hepatitis B Adults)

_____ 90651 Gardasil 9 (HPV)

_____ 90707 MMR II (Measles, Mumps, Rubella

_____ 90734 Menveo (Meningitis ACWY)

_____ 90620 Bexsero (Meningitis B)

_____ 90670 Prevnar 13 (PCV13)

_____ 90732 Pneumovax 23 (PPSV23)

_____ 90750 Shingrix (Shingles)

_____ 90714 Td (Tetanus, Diphtheria only)

_____ 90715 Boostrix -TDAP (Tetanus Diphtheria Pertussis)

_____ 90716 Varivax (Chicken Pox)

_____ Recent Injury/Exposure (Modifier AT)

Other Vaccine: _____ CPT code: _____

Codes for Administration of Vaccine

_____ 90471 Administration, 1 vaccine

_____ 90472 Administration, each additional vaccine

_____ 90473 Administration for **1 FluMist**

_____ 90474 Administration for **FluMist PLUS Additional vaccine**

_____ G0008 **MEDICARE**- **Any Flu** Administration

_____ G0009 **MEDICARE**- **Any Pneumonia** Administration

_____ G0010 **MEDICARE**- **Hep B** Administration

Vaccine Administration Record

Vaccine	Date Administered	Site and Route	Manufacturer / Lot No.	Current VIS Date	Date VIS given to patient
Influenza				8/7/2015	
Twinrix Combination Hep A & Hep B				7/20/2016	
Havrix for Pediatrics & Vaqta for Adults Hepatitis A				7/20/2016	
Energix for Pediatrics & Adults Hepatitis B				7/20/2016	
Gardasil 9 HPV				12/2/2016	
MMR II Measles, Mumps, Rubella				2/12/2018	
Menveo Meningitis ACWY				3/31/2016	
Bexsero Meningitis B				8/9/2016	
Prevnar 13 Pneumonia conjugate PCV13				11/5/2015	
Pneumovax 23 Pneumonia polysaccharide PPSV23				4/24/2015	
Shingrix Shingles				2/12/2018	
TD Texanus Toxoid/Dipththeria				4/11/17	
Boostrix Tdap				2/24/2015	
Varivax Chicken Pox				2/12/2018	
Other					

Vaccine(s) administered by: _____ Title: _____ (rev. 7/25/18)