Cumberland County Health Department

19 YEARS AND OLDER VACCINE DOCUMENTATION/CONSENT FORM

DEMOGRAPHICS

Patient's First Name: **Middle Name:** **Last Name:** **Maiden Name/Alias:**

Birth Date: MM/DD/YYYY	**Age:**	**Phone Number:**	**Social Security Number:**	**Primary Language:**

Ethnicity: Hispanic ____Yes ____No

Gender Male Female

Race:

___ Asian/Pacific Islander/Other
___ Black or African American
___ Native American/Alaska Native
___ Caucasian or White
___ Hawaiian
___ Unknown or Other____

Marital Status
___ Single ___ Divorced
___ Married ___ Widowed

Mailing Address:	**Apt #:**	**City:**	**State:**	**County:**	**Zip Code:**

BILLING

Primary Insurance Carrier

Insurance Co. Name _____ ID#:_____ Group#_____

Policy Holder (Name): _____ Policy Holder's Birthdate: _____

Patients relationship to policy holder (child, spouse, self) _____

Secondary Insurance Carrier

Insurance Co. Name _____ ID#:_____ Group#_____

Policy Holder (Name): _____ Policy Holder's Birthdate: _____

Patients relationship to policy holder (child, spouse, self) _____

By my signature below, I authorize the Cumberland County Health Department to bill any of the medical payers as indicated above and provide necessary information to process claims. I authorize payment of medical benefits to the Cumberland County Health Department for services rendered and I understand I will be responsible for payment of charged deemed "uncovered" by my health insurance.

All records of services rendered are considered confidential. This constitutes advance notice to you, the beneficiary, that if all program requirements are met by the Cumberland County Health Department and payment is not made by your Health Insurance, you may be responsible for the charges. You may also be responsible for charged if you fail to inform the Health Department of Insurance coverage in a timely manner. The undersigned has read the above authorization and understands the same. I certify that the information provided on this page is true and correct to the best of my knowledge. I acknowledge that I was offered a copy of the CCHD Privacy Policy dated 9-2016.

SIGNATURE _____ **DATE** _____

IMMUNIZATION SCREENING QUESTIONNAIRE

1. Are you sick or experiencing a high fever?	Yes	No
2. Do you have allergies to medications, food, a vaccine component, or latex? List:	Yes	No
3. Have you ever had a serious reaction after receiving a vaccination? Please explain:	Yes	No
4. Have you had a seizure, a brain disorder, Guillain-Barré syndrome, or other nervous system problem?	Yes	No
5. **For women:** Are you pregnant or is there a chance you could become pregnant during the next month? If pregnant, how many weeks gestation? _____	Yes	No

Reviewed by:_____ Date: _____

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VACCINE CONSENT

I have been offered a copy of the Vaccine Information Statement(s) (VIS) checked below. I have read, had explained to me, and understand the information in the VIS(s). I ask that the vaccine(s) checked below be given to me or to the person named below for whom I am authorized to make this request. I consent to inclusion of this immunization data in the North Carolina Immunization Registry for myself or behalf of the person named on this form.

☐ Tdap ☐ Td ☐ Hepatitis A ☐ Hepatitis B ☐ Twinrix ☐ Meningococcal B ☐ Meningococcal (A,C,Y,W-135)

☐ MMR ☐ Varicella ☐ Shingrix ☐ Hib ☐ Polio/IPV ☐ Influenza ☐ Gardasil 9

☐ Prevnar 13 ☐ PPSV23 ☐ Typhoid ☐ Pre-Exposure Rabies

SIGNATURE _____ **DATE** _____

FOR CLINICAL USE ONLY

VACCINE	DOSE	EXT	SITE	ROUTE	VIS DATE	MANUFACTURER LOT #	EXP DATE
Td / Tdap	0.5 mL	RT LT	Deltoid	IM	Documented in NCIR		
Hepatitis A	1.0 mL	RT LT	Deltoid	IM	Documented in NCIR		
Hepatitis B	1.0 mL	RT LT	Deltoid	IM	Documented in NCIR		
Twinrix (Hepatitis A & B)	1.0 mL	RT LT	Deltoid	IM	Documented in NCIR		
Act Hib, Pedvax	0.5 mL	RT LT	Deltoid	IM	Documented in NCIR		
HPV (Gardasil 9)	0.5 mL	RT LT	Deltoid	IM	Documented in NCIR		
Influenza (IIV4) Fluzone, Flublok, High Dose	0.50mL	RT LT	Deltoid	IM	Documented in NCIR		
MCV4/MPSV4 (Menveo/Menactra	0.5 mL	RT LT	Deltoid	IM	Documented in NCIR		
Meningococcal B	0.5 mL	RT LT	Deltoid	IM	Documented in NCIR		
MMR	0.5 mL	RT LT	Upper Arm	SC	Documented in NCIR		
Varicella	0.5 mL	RT LT	Upper Arm	SC	Documented in NCIR		
PCV13 (Prevnar 13)	0.5 mL	RT LT	Deltoid	IM	Documented in NCIR		
Polio/IPV	0.5 mL	RT LT	Upper Arm Deltoid	IM SC	Documented in NCIR		
PPV23	0.5 mL	RT LT	Deltoid	IM	Documented in NCIR		
Shingrix	0.5mL	RT LT	Deltoid	IM	Documented in NCIR		
Typhim Vi (≥ 2 years)	0.5 mL	RT LT	Deltoid	IM	Documented in NCIR		
Pre-Exposure Rabies	0.5 mL	RT LT	Deltoid	IM	Documented in NCIR		

VACCINE ADMINISTRATOR _____ **DATE** _____