CASPER-NATRONA
COUNTY HEALTH DEPARTMENT

ADULT IMMUNIZATION CONSENT & ADMINISTRATION FORM

PATIENT INFORMATION:

Last Name: _____ First Name: _____ Middle Initial: ___ WY Resident: Yes or No

Mailing Address: _____ City/State/ZipCode: _____

Primary Phone #: _____ Date of Birth: _____ Age: _____

Gender Identity: ☐Male ☐Female ☐Other _____

EMPLOYER RESPONSIBILITY: Yes or No If "Yes", Employer Name: _____

INSURANCE STATUS: ☐ Uninsured ☐ Underinsured ☐ Insured (billing insurance)
☐ Insured (choosing not to bill; paying out of pocket) ☐ Medicaid ☐ Medicare Part B

SCREENING QUESTIONAIRE

Are you ill today? ..... Yes or No
Have you ever had a severe allergic reaction (anaphylaxis) to a vaccine in the past? ..... Yes or No
Do you have severe allergic reactions to latex or yeast? ..... Yes or No
Do you have a history of Guillain-Barre Syndrome (a paralysis problem)? ..... Yes or No
Do you have any medical conditions or take any medications that make you severely immunocompromised? ..... Yes or No
Do you have any of the following conditions (please check all that apply)?

☐Heart disease (excluding HTN) ☐Lung disease ☐Asthma ☐History of Smoking ☐Liver Disease ☐Diabetes ☐Alcoholism

☐Chronic Renal Failure ☐Nephrotic Syndrome ☐Asplenia (no spleen) ☐CSF Leaks ☐Cochlear Implants

Have you ever received a vaccine for pneumonia? ..... Yes or No

- If "Yes", which one? ☐ Pneumonia 13 ☐Pneumonia 23 Date received:_____

Have you ever received a flu vaccine? ..... Yes or No
In the past 4 weeks, have you received any live vaccines such as MMR, Varicella (chickenpox), Yellow Fever, or Flu Mist? ..... Yes or No
Have you ever had chickenpox disease? ..... Yes or No
FEMALES ONLY: Are you pregnant or is there a chance you could become pregnant within the next 4 weeks? ..... Yes or No

I have been offered the Vaccine Information Statement about the vaccine(s) to be given today. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) and ask that the vaccine(s) be given to me or the patient named above for whom I am authorized to make this request as their legal guardian.

The Notice of Privacy Practices describes how CNCHD may use or disclose information. Not all situations may be described. CNCHD is required to offer its clients a Notice of Privacy Practices pertaining to information we use, maintain, and disclose. I have been presented with a copy of the CNCHD Notice of Privacy Practices. I have had the chance to ask questions that were answered to my satisfaction about how my information will be used.

I, HEREBY, ATTEST THAT THE INFORMATION GIVEN ABOVE IS ACCURATE/TRUE, AND I AGREE TO THE TERMS AND CONDITIONS AS SET FORTH ABOVE.

_____ _____
Signature of Patient *(Print & Sign if Legal Representative other than patient)* Date of Signature

----------FOR CLINIC STAFF USE ONLY----------

DATE	VACCINE	LOT#	SITE/ROUTE	PRVT/VUA/AHP	NURSE SIGNATURE