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: _____ Sex Assigned at Birth: ☐Male ☐Female

Gender Identity: ☐Male ☐Female ☐Transgender Male ☐Transgender Female ☐Neither Male/Female ☐Other _____

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

INSURANCE STATUS: ☐ Uninsured ☐ Underinsured
(If not Employer Paid) ☐ Insured (billing insurance) ☐ Insured (choosing not to bill insurance) ☐ Medicaid ☐ Medicare Part B

SCREENING QUESTIONAIRE

Are you ill today? ..... Yes or No
Do you have a fever today? ..... Yes or No
Do you have a history of Guillain-Barre Syndrome (a paralysis problem)? ..... Yes or No
Do you have allergies to medications, eggs, other foods, vaccines, or latex? ..... Yes or No
- If "Yes", please list:_____

Do you have an allergy to phenol (a preservative)? ..... Yes or No
Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem? ..... Yes or No
Do you have heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g. diabetes), anemia, or other blood disorder? ..... Yes or No
Have you ever had a seizure or brain/nervous system problem? ..... Yes or No
Have you ever had a serious reaction after receiving a vaccination? ..... Yes or No
Have you ever received the influenza vaccine? ..... Yes or No
Have you ever received the pneumococcal vaccine? ..... Yes or No
- If "Yes", what type? ☐ Pneumonia 13 ☐Pneumonia 23 Date received:_____

In the last 4 weeks, have you received any vaccinations? ..... Yes or No
In the last 3 months, have you received cortisone, prednisone, other steroids, anticancer drugs, or radiation treatments? ..... Yes or No
In the last 12 months, have you received a blood/blood products transfusion or been given immune (gamma) globulin or antiviral drugs? ..... 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 read, or have had it explained to me, the Vaccination 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 furnish its clients with a Notice of Privacy Practices pertaining to information we use, maintain, and disclose. I have received and read 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.

_____ _____
Printed Name of Patient (If applicable, legal guardian) Relationship to Patient

_____ _____
Signature of Patient (If applicable, legal guardian) Date of Signature

FOR CLINIC STAFF USE ONLY

VACCINE	LOT #	SITE / ROUTE

VUA Eligible: Yes or No

Nurse's Signature:

_____

WYIR Entered: _____