

INFORMATION ABOUT PERSON TO RECEIVE VACCINE (PLEASE PRINT)

MUST BE <u>LEGAL</u> NAME				Birth date	Sex	Age
Last	First	Middle				
Address			City	State	Zip	Last 4 digits of your Social Security Number:
Phone #		Physician Name:		Are you an Active or Retired State Employee: (flu only) Yes or No If yes-Who is/was employer: _____		
RACE: (circle all that apply) White; American Indian/Alaska Native; Asian; Black/African American; Native Hawaiian; OR Other						
ETHNICITY: (circle all that apply) Hispanic; Non-Hispanic; Asian; OR Mixed Race						

- | | | |
|--------------------------|--------------------------|--|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Is the client sick today? |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Is the client allergic to eggs, baker's yeast, neomycin, sorbitol, latex or any vaccines? |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Has the client had a serious reaction to any vaccine in the past? |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Does the client have uncontrolled epilepsy or a history of seizures or other neurological problems? |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Does the client have cancer, leukemia, HIV or any other immune system problem; in the last 3 months taken prednisone, other steroids, anticancer drugs, treatment for rheumatoid arthritis, Crohn's or had radiation treatment? |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Has the client received a transfusion of blood, plasma or a medicine called immune globulin or antiviral drug in the past year? |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Is the client pregnant or at risk for becoming pregnant within the next three months? |

"I have read or have had explained to me by the nurse the VIS about the vaccine and all components that will be administered. I understand the potential contraindications to receiving the vaccine. My questions have been answered and I understand the risks and benefits of the vaccine and all the various vaccine components. I give my consent for the vaccine and all the various components to be administered to me or to the person named for whom I am authorized to make this request."

I request that Livingston County Health Department (LCHD) bill my insurance/Medicare/Medicaid policy for services rendered and authorize the payment of benefits be made on my behalf to LCHD for those services. I understand that I am responsible for payment for any deductible, co-pays, or any non-covered service furnished. In the event of non-coverage, financial arrangements can be made with LCHD.

Signature of person to receive vaccine or person authorized to make requests.

X _____ Date _____
(Patient/Parent/Legal Guardian Adult Accompanying Child)

X _____ Date of Birth _____
PRINT NAME LEGIBLY RELATIONSHIP TO PATIENT Responsible Parent or Guardians

Cash\$ _____ Check\$ and # _____ No Charge _____

Credit Card Vendor & Amt _____ Medicaid Number _____

Bill to Insurance – copy of insurance attached (need subscriber Date of Birth if not patient) _____

Vaccine Administration Record for Adults

Patient Name _____ Birthdate _____

Date Vaccine & Info Sheet (VISs) given _____

Before administering any vaccines, give the patient copies of all pertinent Vaccine Information Statements (VISs) and make sure he/she understands the risks and benefits of the vaccine (s).
If client refuses vaccine, make note next to the vaccine.

Clinic Site _____

Vaccine	Type of Vaccine	Site	Vaccine Lot#	Vaccine Exp Date	Date on VIS	Vaccinator
Haemophilus influenza	ActHIB (Sanofi) Hiberix (GSK) PedvaxHIB (Merck)					
Hepatitis A	Havrix (GSK) Vaqta (Merck)					
Hepatitis B	Engerix-B (GSK) Recombivax HB (Merck)					
Hep A - Hep B	Twinrix (GSK)					
Human papillomavirus	Gardisil 9 (Merck)					
Influenza	Fluarix (GSK) Fluzone High Dose (Sanofi)					
Japanese Encephalitis	Ixiaro Jap B Encp (Sanofi)					
Meningococcal ACWY; CY	Menactra (Sanofi) Menveo (GSK)					
MMR	MMRII (Merck)					
Pneumococcal	Pneumovax 23 (Merck) Prennar 13 (Pfizer)					
Polio (IPV)	Ipol (Sanofi)					
Rabies	Imovax (Sanofi) Rabavert (GSK)					
Td	Decavac, Tenivac (Sanofi) Generic (MA Lab)					
Tdap	Adacel (Sanofi) Boostrix (GSK)					
Typhoid	Typhim VI (Sanofi) Vivotif (Pax Vax Inc.)					
Varicella	Varivax (Merck)					
Yellow Fever	YF-Vax (Sanofi)					
Zoster	Zostavax (Merck)					
Other						

Entered into ICARE by _____