

<b>First Name</b>	<b>MI</b>	<b>Last Name</b>	<b>Gender</b>	<b>Age</b>
<b>Address</b>		<b>City</b>	<b>State</b>	<b>Zip code</b>
<b>Phone:</b>	<input type="text"/>	<b>Email:</b>	<input type="text"/>	<b>Birthdate:</b>
	<input type="text"/>		<input type="text"/>	<input type="text"/>
				MM/DD/YYYY
<b>Race :</b>	<b>Ethnicity (Please circle one) :</b>		<b>Preferred Language :</b>	
	<input type="checkbox"/> Hispanic/ Latino <input type="checkbox"/> Not Hispanic/Latino			

<b>NO INSURANCE - PLEASE FILL OUT</b>	<b>Household Size:</b>	<input type="text"/>	<b>Household Income:</b>	<input type="text"/>	<b>Per Week/Month/Year</b>
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Please Answer the following Questions	Yes	No
Are you sick today?		
Do you have allergies to medications, food, a vaccine component, or latex?		
Have you ever had a serious reaction after receiving a vaccination?		
Do you have a long-term health problem with heart, lung, kidney, neurologic, liver, or metabolic disease (e.g., diabetes), asthma, or a blood disorder?		
Do you have cancer, leukemia, HIV/AIDS, or any other immune system problems; or in the past 3 months, have you taken medications that affect the immune system such as prednisone, other steroids, long-term aspirin therapy, anti-viral drugs, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?		
Have you had a seizure or a brain or other nervous system problem? (Guillain Barre Syndrome)		
Do you live with or have close contact with someone who is in protective isolation (e.g. bone marrow transplant unit) ?		
Have you received vaccinations in the past 4 weeks?		
For Females: Are you pregnant or is there a chance you could become pregnant during the next month?		
Are you planning to come back to Delaware General Health District for future vaccinations?		
Have you visited your primary care doctor in the past year?		
<b>Primary Physician:</b> <input type="text"/> <b>Location:</b> <input type="text"/>		
<input type="checkbox"/> I do not have a primary care doctor.		

The Delaware General Health District may keep this record in my medical file. DGHD will record what vaccine was given, the date the vaccine was given, the name of the company that made the vaccine, the vaccine lot number, the signature and title of the person who gave the vaccine, and the address where the vaccine was given. I understand that this information will be released to a state-wide Immunization Registry for the purpose of immunization tracking recall and recording, unless I request otherwise. I have read or have had explained to me the information sheet about the vaccine. I have had a chance to ask questions, and they were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and ask that the vaccine be given to the person named above for whom I am authorized to make this request. My medical information will not be shared without an authorization to release information. A copy of the Health Districts Notice of Privacy Practices (HIPAA) will be provided and is also located on our website at delawarehealth.org.

<b>Patient Signature:</b> <input type="text"/>	<b>Date:</b> <input type="text"/>
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<input type="checkbox"/> <b>Primary Insurance Card Scanned</b>	<input type="checkbox"/> <b>Secondary Insurance Card Scanned (If Applicable)</b>	<b>SKIP Below if insurance cards have been scanned</b>
<b>Insurance Company</b>	<b>Member ID</b>	<b>Group #</b>
<b>Claim Submission Address</b>	<b>Social Security #</b>	
<b>Primary Insured Name</b>	<b>Birthdate</b>	<b>Relationship to Patient:</b>
<b>Address (If different from patient)</b>		

VACCINE	DOSE #	LOT #	SITE	RN SIGNATURE	DATE
HPV - IM GARDASIL 9 90651			LD RD		
HAV - IM Vaqta 90633			LVL RVL LD RD		
HBV - IM Engerix - B / Recombivax HB 90744			LVL RVL LD RD		
IPV - SQ / IM IPOL 90713			LVL RVL LA RA LD RD		
MENINGOCOCCALACWY - IM Menectra 90734			LD RD		
MENINGOCOCCAL B - IM Trumemba 90621 Bexsero 90620			LD RD		
MMR - SQ MMR-II 90707			LVL RVL LA RA		
PNEUMOCOCCAL 23 IM 90732			LD RD		
PREVNAR-13 - IM 90670			LVL RVL LD RD		
Shingles Shingrix 90750			LD RD		
RABIES - IM Rabavert / Imovax 90675			LD RD		
TDAP- IM Adacel / Boostrix 90715			LD RD		
TD - IM 90714			LD RD		
VARICELLA - SQ Varivax 90716			LVL RVL LA RA		
High Dose Flu 90662			LVL RVL LD RD		
Flu Pres. Free - IM 90686			LVL RVL LD RD		
Flu Mist 90672			Nasal		
FluBlok - IM 90682			LVL RVL LD RD		
JE -VC - IM Japanese Encephalitis IXIARO 90738			LD RD		
Typhoid - IM Typhim Vi 90691			LD RD		

<b>Administrative Assistant</b>	
<b>DELAWARE</b>	<b>SUNBURY</b>
<b>Time IN</b>	
<b>NN Number</b>	
<b>Insurance Verified or % on Sliding Fee</b>	
<b>Primary Pay Source</b>	
<b>STATE</b>	<b>PRIVATE</b>
<b>NN Completed</b>	
<b>Impact Completed</b>	

<b>NURSE - INITIALS</b>	
<b>Time completed</b>	
<b>NN Completed</b>	
<b>Impact Completed</b>	

<b>ACTIVE</b>	<b>INACTIVE</b>
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<b>Diluent</b>
<b>Notes</b>