Delaware Public Health District
Dedicated to your health

Adult Consent Form
Please Print Clearly

First Name _____ MI _____ Last Name _____ Gender _____ Age _____

Address _____ City _____ State _____ Zip code _____

Phone: _____ Email: _____ Birthdate: _____ MM/DD/YYYY

Race : _____ Ethnicity (Please circle one) : Hispanic/ Latino Not Hispanic/Latino Preferred Language : _____

NO INSURANCE - PLEASE FILL OUT →	Household Size:		Household Income:		Per Week/Month/Year

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?		
Have you been identified as either a probable of confirmed case of COVID-19 in the past three months?		
Are you planning to come back to Delaware Public Health District for future vaccinations?		

Primary Physician: _____ Location: _____

☐ I do not have a primary care doctor.

The Delaware Public Health District may keep this record in my medical file. DPHD 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.

Patient Signature: _____ **Date:** _____

☐ Primary Insurance Card Scanned ☐ Secondary Insurance Card Scanned (If Applicable) SKIP Below if insurance cards have been scanned

Insurance Company _____ Member ID _____ Group # _____

Claim Submission Address _____ Social Security # _____

Primary Insured Name _____ Birthdate _____ Relationship to Patient: _____

Address (If different from patient) _____

VACCINE	DOSE #	LOT #	SITE	RN SIGNATURE	DATE
HPV - IM GARDASIL 9 **90651**			LD RD		
HAV - IM Vaqta **90632**			LVL RVL LD RD		
HBV - IM Engerix - B / Recombivax HB **90746**			LVL RVL LD RD		
HBV - IM Heplisav **90739**			LVL RVL LD RD		
IPV - SQ / IM IPOL **90713**			LVL RVL LA RA LD RD		
MENINGOCOCCALACWY - IM Menquadfi **90619**			LD RD		
MENINGOCOCCAL B - IM **Trumemba 90621** **Bexsero 90620**			LD RD		
MMR - SQ MMR-II **90707**			LVL RVL LA RA		
PREVNAR-20 - IM **90677**			LVL RVL LD RD		
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		
COVID-19 - IM Moderna / Pfizer			LVL RVL LD RD		

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

NURSE - INITIALS	
Time completed	
NN Completed	
Impact Completed	

ACTIVE	INACTIVE

Diluent

Notes