

Adult Consent Form

First Name: _____ MI: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____ Birthdate: _____ Age: _____

Race: _____ Preferred Language: _____ Sex ☐ Male ☐ Female **Hispanic/Latino?** ☐ Yes ☐ No

Please Answer the Following Questions:	Yes	No	Not Sure
1. Are you sick today?			
2. Do you have allergies to medications, food, a vaccine component, or latex?			
3. Have you ever had a serious reaction after receiving a vaccine?			
4. Do you have any of the following: a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak? Are you on long-term aspirin therapy?			
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?			
6. Do you have a parent, brother, or sister with an immune system problem?			
7. In the past 6 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?			
8. Have you had a seizure or a brain or other nervous system problem?			
9. Have you ever been diagnosed with a heart condition (myocarditis or pericarditis) or have you had Multisystem Inflammatory Syndrome (MIS-A or MIS-C) after an infection with the virus that causes COVID-19?			
10. In the past year, have you received immune (gamma) globulin, blood/blood products, or an antiviral drug?			
11. Are you pregnant?			
12. Have you received any vaccinations in the past 4 weeks?			
13. Have you ever felt dizzy or faint before, during, or after a shot?			
14. Are you anxious about getting a shot today?			
Questions 15-21 for TB Testing ONLY:	Yes	No	Not Sure
15. Have you ever had a TB skin test before?			
16. Have you ever had a positive TB skin test?			
17. Have you ever been diagnosed with TB?			
18. Have you ever been told not to have a TB skin test?			
19. Have you been asked to come in for a test because someone you know has been diagnosed with TB?			
20. Have you had BCG vaccination before?			
21. Do you need a 2-step TB skin test? (2 tests performed within 1-3 weeks; Some health care workers need this)			

Are you the insurance subscriber/policyholder? ☐ Yes ☐ No *if no, please complete subscriber's information below*

Insurance Subscriber's First and Last Name: _____ Sex ☐ Male ☐ Female

Insurance Subscriber's Date of Birth: _____ Relationship to Patient: _____

Address (if different than patient): _____

If you do not have insurance, please answer the following:

Household Size: _____ Household income: _____ Frequency of income: ☐ per week ☐ per month ☐ per year

The Delaware Public Health District may keep this record in the patient's medical file. DPHD will record what vaccine or service was given, the date the vaccine or service 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 and any screening or service provided with date and person providing the service. 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 understand that this information will be released and received from a healthcare provider interoperability Hub (e.g. carequality/ commonwell) for the purpose of sharing and providing patient care, unless I request otherwise. I understand that appointment, cancellation, and reminder information will come to me through email, phone call, and/or text, unless I request otherwise. By sharing your mobile phone information with us, you agree to receive periodic text messages with a link to access your account online, which allows you to view and pay for balances you are responsible for. I understand these permissions will be valid until revoked. For TB: The clinic will keep this form for seven years if result is negative and permanently if the result is positive. It will include information when TB test was given, PPD lot #, result and name and address of where the test was given.

I have read or have had explained to me the information sheet about the vaccine, TB test, or service to be received today. 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 or service and ask that the vaccine or service be given to the person named above for whom I am authorized to make this request. Except as outlined above and in the notice of privacy practices, my medical information will not be shared without an authorization to release information. I have received the Health District's Notice of Privacy Practices (HIPAA) and it is also located on our website at delawarehealth.org. I authorize my insurance company to assign the amount payable directly to DPHD. I understand that I am financially responsible for all the charges that are not covered under my insurance plan or elective service. I acknowledge that any co-payment is due and payable on the date services are received.

Patient Signature: _____ **Date:** _____

VACCINE		CPT	Route	Dose #	Lot #			SITE			
Chikungunya-IXCHIQ		90589	IM					LD	RD	LVL	RVL
Cholera- Vaxchora		90625	PO					Mouth			
COVID-19 –Moderna Monov 12+		91322	IM					LD	RD	LVL	RVL
Flu Pres. Free – Fluzone 6m+ PFS Fluarix		90656	IM					LD	RD	LVL	RVL
Flu (ccIIIV4)- Flucelvax 6mo PFS		90661	IM					LD	RD	LVL	RVL
High Dose Flu – Fluzone High Dose-PRV		90662	IM					LD	RD		
FluMist		90660	Nasal					Nasal			
HepA- Adult 1.0ml– Vaqta Adult		90632	IM					LD	RD	LVL	RVL
HepB- Adult 1.0ml (3 dose_ Engerix-B Adult PFS Recombivax HB Adult PFS		90746	IM					LD	RD	LVL	RVL
HepB 2 dose - Heplisav B		90739	IM					LD	RD	LVL	RVL
HIB - ActHIB		90648	IM					LD	RD	LVL	RVL
HPV - GARDASIL 9		90651	IM					LD	RD	LVL	RVL
IPV - IPOL		90713	SQ / IM					LD LA	RD RA	LVL LT	RVL RT
JE –VC (IXIARO) – Japanese Encephalitis		90738	IM					LD	RD	LVL	RVL
MENINGOCOCCAL ACWY - MenQuadfi		90619	IM					LD	RD	LVL	RVL
MENINGOCOCCAL B - Bexsero		90620	IM					LD	RD	LVL	RVL
MMR- MMRII		90707	SQ					LA	RA	LT	RT
Pneumo 20 - PREVNAR 20		90677	IM					LD	RD	LVL	RVL
Pneumo 21– Capvaxive		90684	IM					LD	RD	LVL	RVL
RABIES - Imovax		90675	IM					LD	RD	LVL	RVL
RSV- Adult - Arexvy		90679	IM					LD	RD		
SHINGLES – Shingrix		90750	IM					LD	RD		
TDAP- Adacel		90715	IM					LD	RD		
Typhoid – Typhim Vi		90691	IM					LD	RD	LVL	RVL
VARICELLA - Varivax		90716	SQ					LA	RA		
Yellow Fever		90717	SQ					LA	RA	LT	RT
TB Step 1	Placed: Time:	RN:	Read: Time:	RN:	Assess: mm	Result: + / -	Lot #:	LFA RFA			
TB Step 2	Placed: Time:	RN:	Read: Time	RN:	Assess: mm	Result: + / -	Lot #:	LFA RFA			

Vaccine Administrator Signature: _____ **Date:** _____

Admin

Delaware [] Other location: _____ VFC [] State [] Private [] Insurance Verified or % on Sliding Fee: _____

Primary Pay Source: _____ Member ID: _____ Payor ID _____

Secondary Pay Source: _____ Member ID: _____ Payor ID _____

eCW Chart created: _____ Scanned into eCW: _____

Nurse

ImpactSIIS Status: ACTIVE / INACTIVE

eCW charting completed: _____

Notes:

