Adult Immunizations

Registered: _____
Scanned: _____
EZ Imm Doc: _____
ICARE: _____

Last Name _____ First_____ MI_____

Date of Birth _____/_____/_____ Age _____ Male Female Other

Street Address_____ Phone_____

City _____ Zip _____ PID/MRN _____

SELF PAY
MEDICARE
MEDICAID
PRIVATE

Select	Vaccine	Lot#	Site	Nurse Date/Time	Price
	Hep A				$95.00
	Hep B				$90.00
	HIB				$40.00
	HPV				$295.00
	Japanese Encephalitis (Special Order)				$350.00
	Meningococcal				$170.00
	Meningococcal B				$240.00
	MMR II				$105.00
	Pneumococcal 20				$310.00
	Pneumococcal 23				$140.00
	Polio				$50.00
	TD (Special Order)				$50.00
	TdaP				$60.00
	Twinrix (Hep A – Hep B)				$140.00
	Typhoid				$130.00
	Varicella				$180.00
	Yellow Fever (Special Order)				$202.00
	Zoster (shingles)				$285.00
	Influenza				$35.00
	High Dose Influenza (>65)				$72.00
	COVID: Pfizer 1 2 3*				n/a
	COVID: Moderna 1 2 3*				n/a
	COVID: Novavax 1 2				n/a
	COVID: Pfizer Bivalent Booster				n/a
	COVID: Moderna Bivalent Booster				n/a

***Dose 3 is for immunocompromised individuals only.**

INSURANCE _____
PRIMARY INS. NAME_____ DOB_____/____/_____
MEMBER ID# _____
GROUP #_____

I understand that I have the right to ask questions and be answered to satisfaction. I believe I understand the benefits, the risks of the vaccine(s) and ask the vaccine(s) stated above be given to me or the person above who I am authorized to make this request.

I understand that the HD is authorized to use the information gained during treatment to bill me or any other potential sources of reimbursement, such as government programs in which I am enrolled or qualified for services. Also, by signing I acknowledge that I am responsible for any remaining balance or co-pays that the provided insurance does not cover.

Signature:_____ Date _____

Original 3/22, 6/22, 7/22, 9/22

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

Screening Questions	**Yes**	**No**	**Unsure**
Are you sick today?			
Do you have allergies to medications, food, a vaccine component, latex, eggs or chicken protein, sorbitol, or gelatin? Describe: _____			
Have you ever had a serious reaction after receiving a vaccination? Describe: _____			
Do you have a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Are you on long-term aspirin therapy? Describe: _____			
Do you have cancer, leukemia, HIV/AIDS, or any other illness that may affect your immune system? Or had cancer in the past? Describe: _____			
Do you have a parent, brother, or sister with an immune system problem?			
In the past year, 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 chemotherapy or radiation treatments? Describe: _____			
Have you had a seizure or a brain or other nervous system problem?			
During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?			
For women: Are you pregnant or is there a chance you could become pregnant during the next month? Are you breastfeeding?			
Have you received any vaccinations in the past 4 weeks?			
Have you ever had Guillain-Barre Syndrome?			
ANSWER BELOW QUESTIONS FOR YELLOW FEVER VACCINE ONLY	**Yes**	**No**	**Unsure**
Have you been told that you may have a problem with your Thymus Gland? (Includes myasthenia gravis or a thyoma?			
Have you had open chest surgery?			
Have you had an operation to remove your thymus gland for any reason, including during cardiac surgery?			
Do you have a family member (blood relative) that has had a serious reaction to a yellow fever vaccine?			

- ☐ I would like information on the WIC nutritional supplement program, or other services available at the Health Department
- ☐ I would like to speak to someone regarding a financial assistance program for immunization cost