Transact reg	_____
Scanned	_____
Ez Imm Doc	_____
ICARE	_____
Claim Submit	_____

Medicare Part D Consent Form

Last Name _____ **First Name**_____ **MI**____

DOB _____/____/_____ **Age** _____ **Male Female Other**

Street Address_____

City _____ **Zip** _____ **Phone**_____

SS#/MEDICARE ID_____ **PID/MRN** _____

Race_____ **Ethnicity: Hispanic or Latino NonHispanic/Latino Other**

VACCINE	LOT #	SITE	NURSE/DATE/TIME
Shingrix			
Boostrix			
Energix B (HBV)			
Havrix (HAV)			
Twinrix (HBV/HAV)			
Menveo			
Measles, Mumps, and Rubella-MMR-II			
Gardasil			
Typhim			
Varivax			

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 02/2022, 6/28/22, 7/22. 1/23, 4/23

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?			