

CLINIC ID / SITE

**Wayne County Department of Public Health
Pre- Registration Immunization Consent Form**

(Bring Completed Form to Mass Vaccination Clinics. Pre-Registration Does Not Guarantee Vaccination.)

LAST NAME	FIRST NAME	MI	DATE
DATE OF BIRTH MM/DD/YY	AGE	SEX (circle) M F	DAYTIME PHONE () ()
STREET ADDRESS		CITY	ZIP
INSURANCE NAME / CONTRACT# / POLICY NUMBER			MEDICARE OR MEDICAID

MARK YES OR NO FOR EACH QUESTION

Are you Pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have a chronic medical condition (diabetes, asthma, heart disease)? If yes, what	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have sensitivity to latex?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you live in a household or have contact with a child less than 6 months of age?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you allergic to chicken eggs or Thimerosal (cleaning products or contact lens solution)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have an allergy to neomycin or polymycin? (LIVE -gentamicin, MSG, gelatin, arginine)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have a cold, fever, or acute illness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had another immunization in the last 28 days?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you take Coumadin or Warfarin?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have a history of Guillain-Barre' Syndrome or active neurological disorder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had an adverse reaction to another vaccine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you received the pneumococcal vaccine one or more times in the past? If yes, when?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Date: _____	

I HAVE BEEN GIVEN A COPY OF THE VACCINE INFORMATION SHEET YES NO

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES and
WRITTEN PERMISSION TO USE OR DISCLOSE HEALTH INFORMATION**

I have received a copy of the Notice of Privacy Practices from the Wayne County Department of Public Health and understand that I may contact the person named in it if I have questions about the notice. I further expressly and voluntarily consent for the Wayne County Department of Public Health to use and disclose my health/medical information, as stated in the Notice of Privacy Practices, unless I request otherwise.

CLIENT SIGNATURE	DATE	WITNESS SIGNATURE	DATE
PRINT NAME		NURSE'S SIGNATURE	DATE

THESE BOXES FOR CLINIC USE ONLY

<input type="checkbox"/> INFLUENZA VACCINE <input type="checkbox"/> Novel H1N1 MFR: _____ MFR: _____ LOT: _____ LOT: _____ <input type="checkbox"/> Right Deltoid <input type="checkbox"/> Left Deltoid <input type="checkbox"/> Right Thigh <input type="checkbox"/> Left Thigh <input type="checkbox"/> Dosage <u>0.25 cc</u> <input type="checkbox"/> Dosage <u>0.5cc</u> Nurse Initials: _____ <input type="checkbox"/> Intranasal 0.2mL (0.1mL each nostril) Nurse Initials _____	<input type="checkbox"/> PNEUMOCOCCAL VACCINE MFR: _____ LOT: _____ <input type="checkbox"/> Right Deltoid: <input type="checkbox"/> Dosage <u>0.5cc</u> Nurse Initial: _____ <input type="checkbox"/> Left Deltoid: <input type="checkbox"/> Dosage <u>0.5cc</u> Nurse Initial: _____
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PAYMENT INFORMATION

<input type="checkbox"/> 90658 Flu Injection G0008 Dx V04.81 \$	<input type="checkbox"/> 90732 Pneumonia Injection G0009 DxV03.82 \$	<input type="checkbox"/> 90663 Novel H1N1 Flu Injection G9141 Dx 488.1 \$
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