ADULT IMMUNIZATION FORM

PATIENT'S NAME: _____ DATE:_____
PATIENT'S AGE: _____ DATE OF BIRTH:_____
PHONE: _____ADDRESS:_____
STREET OR PO BOX CITY STATE ZIP CODE
PHYSICIAN: _____

IMMUNIZATIONS NEEDED:

___ TDAP ___ FLU ___ FLU MIST ___PNEUMOVAX 23 ___ SHINGRIX ___TD ___HEP B ___HEP A
___TWINRIX ___ MMR ___ VARIVAX ___ MCV4 ___HPV ___ PCV13 ___ OTHER_____

SCREENING CHECKLIST FOR CONTRAINDICATIONS TO VACCINES FOR ADULTS

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.

	YES	NO	DON'T KNOW
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 vaccination?	☐	☐	☐
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?	☐	☐	☐
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
6. In the past 3 months, have you taken medications that weaken your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?	☐	☐	☐
7. Have you had a seizure or a brain or other nervous system problem?	☐	☐	☐
8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
10. Have you received any vaccinations in the past 4 weeks?	☐	☐	☐

OVER →

Did you bring your immunization record card with you?

__ Yes (Please provide your card)

__ No

It is important for you to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.

Please check one of the following:

___Please bill my private insurance

Do you have your card with you?

__ Yes (Please provide your card)

__ No

___Medicaid

Do you have your card with you?

__ Yes (Please provide your card)

__ No

___No Insurance

___Insurance does not cover immunizations

___Paid with cash, check, debit/credit

___Other

Please read statements before signing this document: Thank you.

I have read or have had explained to me the information contained in the important information statements or vaccine information pamphlet(s) about the disease(s) and the vaccine(s). I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) indicated be given to me or the person named above for whom I am authorized to make this request.

X_____ _____

PATIENT SIGNATURE DATE

NOTICE OF ADMINISTRATIVE USE OF CONFIDENTIAL HEALTH CARE INFORMATION

I authorize my health care provider and local public health agency to collect and enter my immunization records into the Department of Public Health and Human Services' Immunization Information System (IIS/ImMTrax). ImMTrax is a confidential, computer system that contains health departments as well as my health care providers to assist in my medical care and treatment. I understand that I can revoke this authorization and have my record removed at any time by contacting my local county health department.

X_____ _____

PATIENT SIGNATURE DATE