Elkhorn Logan Valley Public Health
Department CLIENT VACCINE CONSENT FORM

Last Name	First Name	Middle Initial	Maiden Name	Date of Birth ____/____/____	Age
Address	City	State	Zip		
Gender: ☐ Male ☐ Female	Phone (_____) _____ - _____	E-Mail address	Name of Physician		

Insurance Status:
- ☐ Private Insurance covers immunizations
- ☐ Private Insurance does NOT cover immunizations
- ☐ Heritage Health / Medicaid
- ☐ American Indian / Alaska Native
- ☐ No Insurance

For private insurance (policy holder information):

Policy Holder Name and Date of Birth:

Name: _____ Date of Birth: ____/____/_____

Client Relationship to Policy Holder:
☐ Self ☐ Spouse ☐ Child ☐ Other

Answer the Following Client Health Questions

Are you sick today?	☐ Yes	☐ No
Have you ever had a serious reaction after receiving a vaccination?	☐ Yes	☐ No
Do you have allergies to medications, food, a vaccine component, or latex?	☐ Yes	☐ No
Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease, (e.g. diabetes) or blood disorders?	☐ Yes	☐ No
Do you have cancer, leukemia, AIDS or any other immune system problem?	☐ Yes	☐ No
Have you ever had a vaccine in the past four weeks?	☐ Yes	☐ No
Do you take cortisone, prednisone, steroids, anticancer drugs, or had recent x-rays?	☐ Yes	☐ No
Has Guillan-Barre syndrome occurred within six weeks of receipt of any prior vaccine?	☐ Yes	☐ No
Do you have a bleeding disorder such as hemophilia or thrombocytopenia?	☐ Yes	☐ No
Do you have an unstable neurological condition such as seizures, brain or nerve problems?	☐ Yes	☐ No
During the past year, have you received a transfusion of blood / blood products, or been given immune (gamma) globulin or an antiviral drug?	☐ Yes	☐ No
For women only: Are you pregnant or breastfeeding a child?	☐ Yes	☐ No

Consent to Vaccinate and Medical Records Release

I have read the Vaccine Information Statement(s) (VIS) given to me about the vaccine(s) the client is receiving today as noted below under "vaccines provided". I understand the vaccines given are based upon those recommended for the client's age, circumstances and/or available vaccine history. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) and their presently known side effects. There is no guarantee of immunity or that the client will not experience an adverse reaction to the vaccine(s). In the event of adverse side effects or that immunity does not occur, I hereby hold ELVPHD harmless for any and all liability to the extent permitted under the law. All vaccines administered by ELVPHD will be entered into NESIIS (Nebraska State Immunization Information System). If applicable, I permit these services to be submitted to insurance. If the insurance does not pay, I understand that I am responsible for payment. ELVPHD provides Privacy Practices upon request from the client and this consent is considered the offer to provide ELVPHD's Privacy Practices. I have had a chance to ask questions about the Privacy Practices, and those questions have been answered to my satisfaction. I authorize ELVPHD to release information from the client's medical record including, but not limited to, the following entities: client family/guardians/representatives requesting the immunization record, child care, school or work-related authorities to prove immunization status, medical providers, medical records, billing and insurance. I authorize ELVPHD to photograph me and/or my child(ren) during the services provided and utilize the image(s) for publishing and/or distribution. ELVPHD will communicate with me regarding immunizations, other services or notifications via text, email, phone or other electronic means and my signature indicates acceptance of those contacts until I revoke the authorization to ELVPHD in writing. I understand that the medical release may be revoked at any time by notifying ELVPHD in writing and the revocation will be effective as of the date notified except to the extent action has already been taken.

X_____ _____

Signature of Patient or Patient's Representative Date

Printed Name: _____ Relationship to Client (if a child):_____

To be completed by staff:

Vaccines Provided:

☐ DTap	☐ HPV	☐ Kinrix	☐ Pediarix	☐ Rotavirus
☐ Hep A	☐ Infanrix	☐ Meningitis	☐ Pentacel	☐ Shingles
☐ Hep B	☐ Influenza	☐ Meningitis B	☐ PCV 13	☐ Td/Tdap
☐ Hib	☐ IPV	☐ MMR	☐ PPSV23	☐ Varicella

☐ Other: _____

To be completed by staff:

Manufacturer: (check which type)

☐ Fluarix (Lot #_____) – exp _____ (Glaxo) – 0.5cc, IM

☐ High-Dose Fluzone (Lot #_____) – exp _____ (Sanofi) – 0.5cc, IM

☐ VFC FluLaval Quad (Lot #_____) – exp _____– 0.5cc, IM
☐ VFC FluZone Quad Peds (Lot #_____) – exp _____– 0.25cc, IM

Injection Site (circle):

Left Deltoid Right Deltoid

Other (specify): _____

Manufacturer: | Lot #: | Exp Date:

Injection Site (circle one): Left Deltoid Right Deltoid
Other (specify) _____

Dosage: 0.5cc Route: IM
Other (specify)

Manufacturer: | Lot #: | Exp Date:

Injection Site (circle one): Left Deltoid Right Deltoid
Other (specify) _____

Dosage: Route: IM
Other (specify)

Manufacturer: | Lot #: | Exp Date:

Injection Site (circle one): Left Deltoid Right Deltoid
Other (specify) _____

Dosage: 0.5cc Route: IM
Other (specify)

Manufacturer: | Lot #: | Exp Date:

Injection Site (circle one): Left Deltoid Right Deltoid
Other (specify) _____

Dosage: 0.5cc Route: IM
Other (specify)

Manufacturer: | Lot #: | Exp Date:

Injection Site (circle one): Left Deltoid Right Deltoid
Other (specify) _____

Dosage: 0.5cc Route: IM
Other (specify)

_____ _____

Signature of Vaccine Administrator Date of Vaccine Administration

For Private Pay Only:
Amount Paid: $_____
☐ Cash ☐ Check (#_____)

☐ NESIIS ☐ Imms SS ☐ Tracking/Billing ss ☐ Ins. Billed: _____