PATIENT INFORMATION & CONSENT

Check the box by each vaccine requested. We accept Aetna, BCBS, Cigna, Humana, United Health & Medicare-flu only

□ **Influenza Shot:** I am not allergic to eggs or egg products or thimerosal, do not have acute febrile illnesses (Fever>101º F) and have not had an anaphylactic reaction or developed Guillain-Barré syndrome after receiving a previous influenza vaccination. **VIS given: annual**

□ **HPV (Gardasil 9):** I have not had a reaction to a prior dose or any vaccine components, am not pregnant, do not have acute febrile illness or a weakened immune system. **VIS given: 8/6/21**

□ **Hepatitis A:** I am not allergic to aluminum hydroxide, sodium borate and /or sodium chloride. **VIS given: 7/28/2020**

□ **Hepatitis B:** I do not have multiple sclerosis and am not hypersensitive to yeast, formaldehyde, aluminum hydroxide or thimerosal. **VIS given: 8/15/19**

□ **Meningococcal:** I am not pregnant. I am not on **anticoagulant therapy** (Menveo). **VIS given: 8/6/21**

□ **Measles Mumps Rubella (MMR):** I have not had a reaction to a prior dose or any vaccine components, am not pregnant, do not have acute febrile illness or a weakened immune system. I have not had another live vaccine in last 4 weeks. **VIS given: 8/6/21**

□ **Pneumonia (PPSV):** I am over 50, have a chronic health condition or am a child at risk. I have not had a Shingles shot within 30 days or a Prevnar13 within 12mos and am not pregnant or on immunosuppressive therapy within 2 mos. or allergic to phenol or bacterial polysaccharides. **VIS given: 10/30/19**

□ **Pneumonia (Prevnar):** I am over 50 and not pregnant or have a chronic health condition or is a child at risk. I have not had a dose of PPSV in the last 12 mos. I am not allergic to Diphtheria. **VIS given: 8/6/21**

□ **Tetanus, Diphtheria and Pertussis (TDAP)**: I am not allergic to aluminum phosphate, formaldehyde, glutaraldehyde, 2-phenoxyethanol or a prior DTaP Vaccine and have not had encephalopathy, or **progressive neurological disorder**. **VIS given: TDAP 8/6/21**

□ **Shingrix(Zoster):** I am at least 50 years old, not pregnant or breastfeeding, have not had a Zostavax vaccine within 8 weeks or a severe allergic reaction to any component of the vaccine (anaphylaxis) or after a previous dose of Shingrix. **VIS given: 10/30/19**

Patient Information Section-attach photocopy of insurance (front only) and driver's license

We don't accept HMOs&BCBS prefix: ISD,NCF,RSK,QSI,UGD,UZF,XZA, ZGP: 000955,090047,00700,045636,ZGN,ZGR, ZGZ , AetnaAssurant SRC, Aetna Exxon or Aetna Bronze, Silver and Gold Plans **We cannot accept ActiveCare Select, and Aetna Whole Health in DFW, Austin or San Antonio areas**

Yes/ No Are you sick today or have you had a fever in the past 48 hours? _____/_____
Yes/ No Are you pregnant or nursing? Primary **Insured ID** **Group#**
Yes/ No Do you have any allergies? List all medicine or vaccine allergies_____
Yes/ No I am giving permission to the vaccinator to provide a copy of my vaccine record (consent) to my employer if requested.

_____ _____ _____ ___/____/____ ___ ___
Patient Last Name First Name Middle I Birth Date M/D/Y Age Sex

If same person, skip this line _____ _____ _____ ___/____/____ ___
Primary Insured Last Name First Name Middle I Birth Date M/D/Y Sex

_____ _____ _____ _____ _____ _____-_____-_____
Patient Address: Street City State County Zip Daytime Phone Number

_____ _____/ _____-_____-_____
Signature of person receiving vaccine or Guardian Emergency Contact Person/ Emergency Phone #

E-mail:

If you have any questions, please ask now or check with your physician before receiving the vaccine. I understand the benefits and risks of these vaccinations and request those indicated above to be given to me. If you experience any significant reactions, see your physician. Please note that by signing this form you are accepting responsibility for all costs not covered by your insurance.

For Clinic Use Only below this point:

Vaccine Administered (nurse checks box by vaccine given)	**Lot #**	**Exp Date**	**Amount/Site**	**Injection Site**
Influenza (SP) Fluzone≥6 mos **□MDV □Thim Free □High Dose >=65yr**	U7328CA	6/30/22	**0.5 ml >3yr IM**	**Left Right**
(GSK) □ Thim Free	308519	6/30/22	**0.25ml ≤ 3yr IM**	
(Seqirus) Flucelvax ≥2yr **□MDV □ Thim Free**	P100355698	6/21/22	**Fluzone &**	
Afluria ≥6 mos **□MDV □ Thim Free**	P100357923 309615	6/28/22 6/29/22	**Afluria only**	
HPV □ Gardasil (Merck) (9-14 or15-45yrs,united to25) 0, 6 to 12 mos or 0, 2, 6mos	S033308	4/8/2022	**0.5 ml IM**	**Left Right**
Hepatitis A □Havrix (GSK),□ Vaqta (Merck)≥1yr 0, 6 months	T018227	12/11/21	**1.0 ml >18yr IM** **0.5 ml ≤18yr IM**	**Left Right**
Hepatitis B □Energix (GSK) □Recombivax (Merck) 0, 1, 6 months	MN7XR 2573G T007984	1/18/22 5/28/22 11/1/22	**1.0 ml > 19yr IM** **0.5 ml ≤19yr IM**	**Left Right**
Meningococcal□Menveo (Nov) (2mo-55y) **□Menactra (SP)** (9mo-55y)	U6921AB U7140BA	4/17/22 11/7/22	**0.5 ml IM**	**Left Right**
MMR □ MMRII(Merck) born after 1957, (0,4wks)	S03664	11/14/21	**0.5 ml SC**	**Left Right**
Pneumonia □Pneumovax (Merck) for adults>50 *NOTE CRITERIA*	T024556	1/8/22	**0.5 ml IM**	**Left Right**
Pneumonia □Prevnar (Pfizer) for adults >50 *NOTE CRITERIA*	CY4764 DL2860	8/31/22 11/30/22	**0.5 ml IM**	**Left Right**
TDAP □Boostrix (GSK) 10+ **□Adacel(SP)**10y-64y, 1 every 5-10yr	FS734 3779R	1/21/22 7/1/22	**0.5 ml IM**	**Left Right**
Shingles □Shingrix (GSK) 0 & 2-6mos for adults>50 and <65	HY4GT G4HX3 4B53D	9/21/21 5/13/22 10/10/22	**0.5 ml IM**	**Left Right**

Nurse Signature: RN Date: Payment Amount: CASH CHECK# OTHER: INSUR BILL