

Vaccine Consent Form

Patient Information (Please Print)			
First Name: _____	MI: _____	Date of Birth _____	Phone #: _____
Last Name: _____		Age: _____	
Mailing Address: _____			SS# or DL# _____
City: _____	State: _____	Zip: _____	County: _____
Gender: _____	Race: _____	Ethnicity: Hispanic/Latino ____ Not Hispanic/Latino ____	
Do you live within Mount Vernon city limits? Yes No			
<p>Complete if the patient is 18 years of age or younger, attending school, or has a legal guardian: For all minor patients (18 years of age or younger), legal guardians will be asked to show documentation to prove that a legal relationship exists. This is for both the safety of the child and guardian and to ensure that the legally appointed parent or guardian is responsible for making medical decisions on behalf of the minor. Applicable legal documents pertaining to custody, divorce, separation, adoption, or name change of parent of child are required.</p> <p>Current Custody Status: ____ Parent ____ Sole Parental Custody ____ Joint Legal Custody ____ DSS Custody ____ Other _____</p> <p>Parent/Guardian Name: _____ Relationship to Patient: _____</p> <p>Home Phone: _____ Cell Phone: _____</p> <p>Mailing Address (if different than patient): _____</p>			
Insurance Information _____ (check here if you do not have health insurance)			
Policy Holder's Name (parent/spouse/guardian): _____			
Policy Holder's Birthdate (parent/spouse/guardian): _____			
I have private health insurance _____	I have Medicare _____	I have Medicaid _____	
Name of Primary Plan: _____	Name of Primary Plan: _____	Name of Primary Plan _____	
Member ID# _____	Member ID# _____	Member ID# _____	
Group # _____	Group # _____	Group # _____	
Name of Secondary Plan _____	Name of Secondary Plan _____	Name of Secondary Plan _____	
Member ID# _____	Member ID# _____	Member ID# _____	
Group # _____	Group # _____	Group # _____	

The Knox Public Health or Health Center may keep this record in your medical file. They will record what vaccine was given, date the vaccine was given, the name of the company that made the vaccine, the vaccine special lot number, the signature and title of the person who gave the vaccine, and the address where the vaccine was given. I understand as a condition of receiving care with KCCHC, my personally identified health information may be disclosed for treatment, payment, and health care operation purposes. I understand that this information will be released to a state-wide Immunization Registry for the purpose of immunization tracking recall and recording. I have read or have had explained to me the Vaccine Information Sheet regarding the vaccine(s) being received today. I have had a chance to ask questions, and they were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and ask that the vaccine(s) be given to the person named above for whom I am authorized to make this request. A copy of the Notice of Privacy Practices (HIPAA) will be provided upon request, and it is also located on our website at www.knoxhealth.com.

Patient/Guardian Signature: _____ Date: _____

Relationship to Patient: _____

Patient Name _____ Date of Birth _____

Vaccine Screening Questions		
1. Are you currently pregnant or breast feeding?	YES	NO
2. Are you sick today?	YES	NO
3. Have you ever had a serious (anaphylactic) reaction after receiving a vaccination?	YES	NO
4. Do you have a weakened immune system?	YES	NO
5. Have you recently received a blood transfusion or received other blood products?	YES	NO
6. Have you received any other vaccines in the last four weeks?	YES	NO
7. Have you received a flu and/or covid vaccine in the past?	___ Flu	___ Covid
8. Children under 9: Have you received two flu vaccines in the past?	YES	NO
9. Have you ever had a paralyzing illness after receiving a flu vaccine? (Guillain Barre)	YES	NO
10. Please list all allergies here: _____		

FOR OFFICE USE ONLY

(Back to School Vaccines)

(Vaccine Source: VFC ___ 317 ___ Private ___)

MMR MMRII ___ Priorix ___ Lot /Expiration _____ Injection Site: _____	Tdap/Dtap Boostrix/Adacel (Tdap) ___ Infanrix/Daptacel (Dtap) ___ Lot /Expiration _____ Injection Site: _____	Meningitis ACWY Menveo ___ MenQuadFi ___ Lot /Expiration _____ Injection Site: _____
Varicella (Varivax) Lot /Expiration _____ Injection Site: _____	Dtap+Polio Kinrix ___ Quadracel ___ Lot /Expiration _____ Injection Site: _____	Hepatitis B Engerix B ___ Recombivax HB ___ Lot /Expiration _____ Injection Site: _____
MMRV (Proquad) Lot /Expiration _____ Injection Site: _____	Polio (Ipol) Lot /Expiration _____ Injection Site: _____	Other: _____ Lot /Expiration _____ Injection Site: _____
Dtap+Polio+Hepatitis B (Pediarix) Lot /Expiration _____ Injection Site: _____	Hib Hiberix ___ Act Hib ___ Lot /Expiration _____ Injection Site: _____	Rotavirus Rotarix ___ RotaTeq ___ Lot /Expiration _____ Injection Site: _____
Pneumonia Prevnar 20 ___ Pneumovax 23 ___ Lot /Expiration _____ Injection Site: _____	Hepatitis A Havrix ___ Vaqta ___ Lot /Expiration _____ Injection Site: _____	Meningitis B Bexsaro ___ Trumenba ___ Lot /Expiration _____ Injection Site: _____
HPV (Gardasil) Lot /Expiration _____ Injection Site: _____	Influenza Regular ___ High Dose ___ Lot /Expiration _____ Injection Site: _____	Shingles (Shingrix) Lot /Expiration _____ Injection Site: _____
COVID 19 Pfizer ___ Moderna ___ Lot /Expiration _____ Injection Site: _____	RSV Beyfortus 50mg/Beyfortus 100mg ___ Abrysvo ___ Lot /Expiration _____ Injection Site: _____	Other _____ Lot /Expiration _____ Injection Site: _____

Name of vaccinator _____ Signature _____ Date _____