Vaccine Consent & Billing Form For Adolescents

PERSONAL INFORMATION

FIRST NAME	MIDDLE INITIAL	LAST NAME		

ADDRESS	CITY	STATE	ZIP

COUNTY	PHONE	GENDER	DATE OF BIRTH	AGE
		☐ Female ☐ Male		

ALLERGIES

SCREENING QUESTIONS

Is the child sick today?	☐ Yes ☐ No
Does the child have allergies to medications, food, a vaccine component, or latex?	☐ Yes ☐ No
Has the child had a serious reaction to a vaccine in the past?	☐ Yes ☐ No
Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), or other blood disorder? Is he/she on long-term aspirin therapy?	☐ Yes ☐ No
If the child to be vaccinated is 2 through 4 years of age, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	☐ Yes ☐ No
If your child is a baby, have you ever been told he/she has had intussusception?	☐ Yes ☐ No
Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	☐ Yes ☐ No
Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐ Yes ☐ No
In the past 3 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?	☐ Yes ☐ No
In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐ Yes ☐ No
Is the child/teen pregnant or is there a chance she should become pregnant during the next month?	☐ Yes ☐ No
Has the child received vaccinations in the past 4 weeks?	☐ Yes ☐ No

Please remain in the pharmacy for 10 minutes following the vaccination. If you leave, you are doing so against medical advice.

Please check the vaccine that is being administered:

☐ Influenza	☐ Hepatitis A	☐ Td	☐ Zoster (Shingles)
☐ Pneumococcal	☐ Hepatitis B	☐ Tdap	☐ Other: _____
☐ HPV	☐ Meningococcal	☐ MMR	

I have read or have had explained to me the information in the *Vaccine Information Statement* about the vaccine that I am requesting. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request. **I understand that I may be held responsible for charges that are not covered by my insurance. I understand that if I do not provide the proper insurance information I may also be held responsible for charges.** For Medicare Recipients: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party that accepts assignment.

SIGNATURE OF PERSON TO RECEIVE VACCINE OR PERSON AUTHORIZED TO MAKE THE REQUEST (PARENT OR GUARDIAN) **DATE**

----------FOR CLINIC/OFFICE USE ONLY----------

IMMUNIZER	DATE OF IMMUNIZATION	VIS DATE

VACCINE	MEDICARE NUMBER	DIAGNOSIS CODE	INSURANCE
		Z23	

ID NUMBER	GROUP NUMBER	CASH