Travel Vaccine Administration Record & Informed Consent

Traveling to: _____
(list all destinations to include City and Region if known)

Departure Date: _____ **Length of Stay:** _____

Patient's Name _____ **Birth Date:** _____ **Age:** _____
Last First

Gender: ☐ Male ☐ Female

Race: ☐ Caucasian ☐ Black or African American ☐ American Indian or Alaskan Native
☐ Asian ☐ Native Hawaiian or other Pacific Islander ☐ Unknown or not reported

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Do you have insurance: ☐ No ☐ Yes **If yes, type:** _____

VFC Eligibility (Clerk use only):
☐ Not Eligible ☐ No Insurance ☐ Underinsured ☐ Native American or Alaskan Native ☐ NV Medicaid ☐ NV Check-Up

The following questions will help us to determine which vaccines may be given today. If a question is not clear, please ask the nurse to explain it.

IS THE PERSON RECEIVING THE VACCINE:	**Yes**	**No**	**Don't Know**
1. Sick today?	☐	☐	☐
2. Allergic to latex, medications, food or any vaccine?	☐	☐	☐
3. Ever had a serious reaction after receiving a vaccine?	☐	☐	☐
4. Had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes, asthma, or a blood disorder)? Is he/she on long-term aspirin therapy?	☐ ☐	☐ ☐	☐ ☐
5. Between the ages of 2 and 4 years and had a healthcare provider tell you that the child had wheezing or asthma in the past 12 months?	☐	☐	☐
6. Been diagnosed with cancer, leukemia, AIDS or any other immune system problem?	☐	☐	☐
7. Taking cortisone, prednisone, other steroids, anticancer drugs or x-ray treatments?	☐	☐	☐
8. Been given a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin during the past year?	☐	☐	☐
9. Had a seizure or a brain problem?	☐	☐	☐
10. Received any vaccinations or TB skin tests in the past four (4) weeks or been told to get a TB skin test?	☐	☐	☐
FOR GIRLS/WOMEN 9 years old or older:			
Are you pregnant?	☐	☐	☐
Are you trying to get pregnant in the next 28 days?	☐	☐	☐
Counseled to avoid pregnancy within the next 28 days: Nurse initial _____ / Patient initial _____	☐	☐	☐

Informed Consent:
I have read or have had explained to me the information contained in the Vaccine Information Statement(s) about the disease(s) and the vaccine(s). I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) indicated on the reverse side be given to me or to the person named above for whom I am authorized to make this request.

Signature of patient (18 yrs. of age and older): _____ Initials: _____ Date: _____

Tele-Interpreter name and number (if required): _____ Verified by initials: _____ Date: _____

Signature of parent or guardian: _____ Initials: _____ Date: _____
(If patient is under 18 yrs. of age)

COMPLETE TOP PART ON BACK (NAME & DOB) ➔

For Staff Use Only	**Nurse Initials**	**Patient Initials**
1. Reviewed key travel information from CDC travel website for destination traveling		
2. Reviewed required and/or recommended travel vaccines with patient and: a. Advised patient of required/ recommended travel vaccines b. Advised patient of required/recommended vaccines that will require patient to follow up with their primary care provider or a travel medicine specialist c. Advised patient they may choose to receive all recommended travel vaccines from their primary care provider, a travel medicine specialist or SNHD		
3. Advise patient that SNHD does not provide the following services: prescription for malaria, diarrhea, altitude sickness, Japanese Encephalitis, oral typhoid vaccine, yellow fever exemption letter, other medical services necessary, blood work to determine immunity. And that if any of these are needed, patient needs to follow up with their primary care provider or a travel medicine specialist.		
4. Patient requested the following vaccines: _____		

Patient's Name_____ **Birth Date**_____

Last First Month Day Year

AREA BELOW FOR SNHD STAFF ONLY							
Vaccine	Date Given	Dose #	Mfg & Lot #	Site*	Route **	VIS Date	Administered by (Name/Title)
DTaP				LA RA LT RT	IM	05-17-07	
DT				LA RA LT RT	IM	05-17-07	
Td				LA RA LT RT	IM	04-11-17	
Tdap Adacel Boostrix				LA RA LT RT	IM	 02-24-15 02-24-15	
IPV				LA RA LT RT	IM SQ	07-20-16	
HIB Ped Vax Act hib				LA RA LT RT	IM	 04-02-15 04-02-15	
MMR				LA RA LT RT	SQ	04-20-12	
Varicella				LA RA LT RT	SQ	03-13-08	
MMRV				LA RA LT RT	SQ	05-21-10	
Hep A				LA RA LT RT	IM	07-20-16	
Hep B				LA RA LT RT	IM	07-20-16	
Hep A/Hep B **Twinrix**				LA RA LT RT	IM	07-20-16 07-20-16	
Meningococcal **Menveo, Menactra** **Menomune** **MenB**				LA RA LT RT	IM SQ	03-31-16 08-09-16	
PCV13				LA RA LT RT	IM	11-05-15	
DTaP/IPV K**inrix**				LA RA LT RT	IM	05-17-07 07-20-16	
DTaP/IPV/HIB **Pentacel**				LA RA LT RT	IM	05-17-07 7-20-16 04-02-15	
DTaP/IPV/Hep B **Pediarix**				LA RA LT RT	IM	05-17-07 7-20-16 07-20-16	
Pneumococcal **Pneumovax**				LA RA LT RT	IM SQ	 04-24-15	
Rabies				LA RA LT RT	IM	10-06-09	
Rotavirus **Rotateq** **Rotarix**				ORAL	PO	 04-15-15 04-15-15	
Flu				LA RA LT RT	IM IN	08-07-15	
Shingles **Zostavax**				LA RA LT RT	SQ	 10-06-09	
HPV Gardasil				LA RA LT RT	IM	12-02-16	
Smallpox				LA RA LT RT	ID		
Typhoid				LA RA	IM	05-29-12	
Yellow Fever				LA RA	SQ	03-30-11	
Newborn Screening							
Multi-Vaccine VIS						11-05-15	

Record # _____ Return Date: _____ VIS Given _____ _____

Clerk Clinician

Clinic Location: ☐ Main ☐ ELV ☐ Hend ☐ Mesquite ☐ _____

Reviewed by: _____ RN / LPN Date: _____

LABEL

Clinical Services Registration Form

Welcome to SNHD!

Please complete this form as completely as possible. Let us know if you have questions or need help.

1. What Services Are You Seeking Today? (Check all that apply)

☐ Immunizations ☐ Kid's Clinic ☐ Family Planning ☐ Refugee Health ☐ Sexual Health Services ☐ Tuberculosis (TB)

2. Client/Patient Information (Please Print in Ink)

Last Name **First Name** **Middle Name**

DOB: Month Day Year Age **Social Security Number** ☐Female ☐Male
Transgender: ☐F to M ☐M to F

Street address **Apt/Bldg #** **City** **State** **Zip Code**

Primary Phone	Work Phone	Alternate Phone
( )	( )	( )
OK to leave message: ☐Yes ☐ No	OK to leave message: ☐Yes ☐ No	OK to leave message: ☐Yes ☐ No

Preferred Method of Contact: ☐Text ☐Phone ☐Mail ☐Email Enter Email Address

Race: Check all that apply	Ethnicity: Check One
☐American Indian or Alaska Native ☐Native Hawaiian/Pacific Islander ☐African American/Black ☐Asian ☐Prefer not to answer ☐Caucasian/White (inc Hispanic) ☐Other_____	☐Non Hispanic ☐Hispanic ☐Prefer not to answer

3. Responsible Party

Name: **Relationship:** ☐Self ☐Parent/Guardian ☐Spouse/Partner ☐Other

☐ Address same as above
If different, please complete. ⇨ **Street Address** **City** **State** **Zip Code**

4. Payment/Insurance Information

PLEASE PROVIDE YOUR INSURANCE/MEDICAID CARD AT TIME OF REGISTRATION.

Do you have Medicaid? ☐Yes ☐No **Do you have other insurance besides Medicaid?** ☐Yes ☐No

Primary Insurance Company **ID Number** **Group Number** **Insurance Co. Contact Number** (On Back of Card)

Name on the Insurance Card **Date of Birth** **Relationship:** ☐Self ☐Parent/Guardian ☐Spouse/Partner ☐Other

☐ Address same as above
If different, please complete. ⇨ **Street Address** **City** **State** **Zip Code**

Secondary Insurance Company **ID Number** **Group Number** **Insurance Co. Contact Number** (On Back of Card)

Name on the Insurance Card **Date of Birth** **Relationship:** ☐Self ☐Parent/Guardian ☐Spouse/Partner ☐Other

☐ Address same as above
If different, please complete. ⇨ **Street Address** **City** **State** **Zip Code**

5. Acknowledgement of Responsibility for Payment for Services and Assignment of Benefits

I certify that the above information is correct to the best of my knowledge. I hereby authorize SNHD to furnish the insured's insurance company all information which said insurance company may request concerning the present services rendered. I assign SNHD all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions. I will notify SNHD in writing of any change in my or my minor child's insurance coverage. This authorization shall continue and be in full force and effect until revoked in writing by me. In the event your account becomes past due, a past due account is an account not paid within 30 days from our 1st date of billing you. In the event that you fail to pay in full or make any satisfactory arrangement for payment or otherwise within 60 days of your 1st bill (or we are unable to notify you) your balance could be turned over to our collection agency. A $25 charge will be assessed to all collection accounts. In addition, you will be responsible for all added percentage based Collection fees/cost per our prevailing collection company contract, attorney fees, court cost, service fees & associated miscellaneous fee/cost.

PRINT NAME: _____ ***SIGNATURE***_____

DATE_____ ***Relationship:*** ☐***Self*** ☐***Parent/Guardian***

Staff Initials_____