# Vaccine Administration Record/Informed Consent

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

**Language most comfortable speaking:** _____ **Do you need an interpreter?** ☐ **Yes** ☐ **No**
**Hearing impaired or need sign language interpreter services?** ☐ **Yes** ☐ **No**

**Did you bring your or your child's immunization record today?** ☐ **Yes** ☐ **No**
**If your child has Nevada Medicaid or Nevada Check-Up, would you like a free children's exam?** ☐ **Yes** ☐ **No**

**PLEASE NOTE:** It is important for you or your child to have a personal record of your vaccinations. If you do not have a record, ask your health care provider to give one to you. Make sure your health care provider records all your vaccinations. Bring this record with you every time you seek medical care.

**I ACKNOWLEDGE THAT I HAVE RECEIVED THE "NOTICE OF PRIVACY PRACTICE."_____ (INITIAL)**

**Patient Emergency Contact**: (For emergency only such as passing out or needing to be taken to a hospital)
**Name**_____ **Relationship**: _____**Phone Number:** _____

**SNHD STAFF ONLY VFC Eligibility**
☐ Not Eligible ☐ No Insurance/Underinsured ☐ Native American or Alaskan Native ☐ NV Medicaid ☐ NV Check-Up

**Complete the following questions to help us 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 vaccines or TB skin tests in the past 4 weeks or been told to get a TB skin test? | | | |
| **FOR FEMALES 9 years old or older:**<br>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_____/Client 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.*

**SIGN HERE:** _____**Date:** _____

☐ Client (18 years of age and older) ☐ Parent/Guardian

**COMPLETE THE TOP PART ON THE BACK (NAME AND DATE OF BIRTH ONLY)**

**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<br>Adacel<br>Boostrix | | | | LA RA LT RT | IM | 02-24-15<br>02-24-15 | |
| IPV | | | | LA RA LT RT | IM SQ | 07-20-16 | |
| HIB<br>Ped Vax<br>Act hib | | | | LA RA LT RT | IM | 04-02-15<br>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<br>**Twinrix** | | | | LA RA LT RT | IM | 7-20-16<br>7-20-16 | |
| Meningococcal<br>**Menveo, Menactra**<br>**MenB** | | | | LA RA LT RT<br>LA RA LT RT | IM<br>IM | 03-31-16<br>08-09-16 | |
| PCV13 | | | | LA RA LT RT | IM | 11-05-15 | |
| DTaP-IPV<br>Ki**nrix** | | | | LA RA LT RT | IM | 05-17-07<br>07-20-16 | |
| DTaP-IPV/HIB<br>**Pentacel** | | | | LA RA LT RT | IM | 05-17-07<br>7-20-16<br>04-02-15 | |
| DTaP-IPV-Hep B<br>**Pediarix** | | | | LA RA LT RT | IM | 05-17-07<br>7-20-16<br>7-20-16 | |
| Pneumococcal<br>**Pneumovax** | | | | LA RA LT RT | IM SQ | 04-24-15 | |
| Rabies | | | | LA RA LT RT | IM | 10-06-09 | |
| Rotavirus<br>**Rotateq**<br>**Rotarix** | | | | ORAL | PO | 04-15-15<br>04-15-15 | |
| Flu | | | | LA RA LT RT | IM IN | 08-07-15 | |
| Shingles<br>**Zostavax** | | | | LA RA LT RT | SQ | 10-06-09 | |
| **HPV**<br>Gardasil | | | | LA RA LT RT | IM | 12-2-16 | |
| 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____

Reviewed by:_____ RN / LPN Date: _____

Clinic Location: ☐Main ☐ELV ☐Hend ☐Mesquite ☐ Mobile Unit ☐Other _____

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<br>☐African American/Black ☐Asian ☐Prefer not to answer<br>☐Caucasian/White (inc Hispanic) ☐Other_____ | ☐Non Hispanic<br>☐Hispanic<br>☐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**_____