MONMOUTH COUNTY REGIONAL HEALTH COMMISSION NO. 1

INFORMED CONSENT FOR RECEIPT OF VACCINE(S)—ADULTS

		Please Circle	
1. Are you sick today OR on antibiotics?	Yes	No	Don't Know
2. Do you have allergies to medications, food, a vaccine component, or latex?	Yes	No	Don't Know
3. Have you ever had a serious reaction after receiving a vaccination?	Yes	No	Don't know
4. Do you have a long-term problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?	Yes	No	Don't Know
5. Do you have cancer, leukemia, AIDS, or any other immune system problem?	Yes	No	Don't Know
6. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?	Yes	No	Don't Know
7. Have you had a seizure, a brain or other nervous system problem?	Yes	No	Don't Know
8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	Yes	No	Don't Know
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	Yes	No	Don't Know
10. Have you received any vaccinations in the past 4 weeks?	Yes	No	Don't Know
11. Are you taking Coumadin or any other prescription blood thinning medicine?	Yes*	No	Don't Know

I've read or had explained to me the information about _____ disease(s), the vaccine(s), and special precautions. I've had an opportunity to ask questions about the specific vaccine(s) which were answered to my satisfaction and I hereby certify that I am 18 years of age or older.

To my knowledge either I or the person I am authorized to make the request for is not allergic to epinephrine (adrenaline) or Benadryl (diphenhydramine) – drugs used to counteract an allergic reaction. If I am taking coumadin or another prescription blood thinner, I have completed the screening survey.

I understand that MCRHC does not accept any Commercial insurances. I hereby acknowledge that I had the opportunity to receive the federal HIPAA notice of privacy information sheet, along with the Vaccine Information Statement(s) for the vaccine(s) I will be receiving.

I believe I understand the benefits and risks of the vaccine(s) and I consent that it (they) be given to me or to the person named below of whom I am the guardian or authorized person. I also permit data to be entered into the NJIIS immunization registry.

Signature: _____ ***Date:*** _____

Person receiving vaccine(s) or Medicare Part B beneficiary

Last Name: _____ **First Name**: _____ **MI**: _____

Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Phone#: ( ) _____ **Birth Date**: _____/_____/_____ **Sex**: M or F **Age**: _____

Part B Medicare #: _____ A-B-C-D ***or*** **Medicaid #**: _____

Payment Amount: _____ **Cash/Check**

Vaccine: _____ Lot #: _____ Manufacturer: _____ Exp.:_____
Date on VIS: _____ Site of Injection: left arm ( ) right arm ( ) Date Vaccine & VIS Given: _____
Signature of Nurse who administered: _____ VFC ARRA MCRHC

Vaccine: _____ Lot #: _____ Manufacturer: _____ Exp.:_____
Date on VIS: _____ Site of Injection: left arm ( ) right arm ( ) Date Vaccine & VIS Given: _____
Signature of Nurse who administered: _____ VFC ARRA MCRHC

Next appointment date (if needed): _____

NJIIS Registry ID: _____