Elkhorn Logan Valley Public Health Department

P / VFC / AIP

CLIENT VACCINE / SERVICES CONSENT FORM

Last Name	First Name	Middle Initial	Maiden Name	Date of Birth ___/___/___	Age

Address	City	State	Zip

Gender: ☐ Male ☐ Female	Phone (___) _____ - _____	E-Mail address	Name of Doctor

Insurance Type:
- ☐ Private Insurance covers immunizations
- ☐ Private Insurance does NOT cover immunizations
- ☐ Heritage Health / Medicaid
- ☐ American Indian / Alaska Native
- ☐ No Insurance

Complete if you have private insurance:

Policy Holder Name:_____

Policy Holder Date of Birth: ___/___/_____

Client Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

Health questions about yourself (or your child) receiving the vaccine(s):

Are you sick today?	☐ Yes	☐ No
Have you ever had a serious reaction after receiving a vaccination?	☐ Yes	☐ No
Do you have allergies to medications, food, a vaccine component, or latex?	☐ Yes	☐ No
Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease, (e.g. diabetes) or blood disorders?	☐ Yes	☐ No
Do you have cancer, leukemia, AIDS or any other immune system problem?	☐ Yes	☐ No
Have you had a vaccine in the past four weeks?	☐ Yes	☐ No
Do you take cortisone, prednisone, steroids, anticancer drugs, or had recent x-rays?	☐ Yes	☐ No
Do you have a bleeding disorder such as hemophilia or thrombocytopenia?	☐ Yes	☐ No
Do you have an unstable neurological condition such as seizures, brain or nerve problems?	☐ Yes	☐ No
During the past year, have you received a transfusion of blood / blood products, or been given immune (gamma) globulin or an antiviral drug?	☐ Yes	☐ No
During the past 3 months have you tested positive for Covid or received monoclonal antibody Therapy or convalescent serum?	☐ Yes	☐ No
For women only: Are you pregnant or breastfeeding a child?	☐ Yes	☐ No
For women only: Have you completed a mammogram in the past 2 years?	☐ Yes	☐ No
For women only: Have you completed a cervical / pap screening in the past 3 years?	☐ Yes	☐ No

Consent to Vaccinate/Provide Services and Medical Records Release

X_____ _____

Signature of Patient or Patient's Representative — Date

Printed Name: _____ Relationship to Client (if a child):_____

I have read the Vaccine Information Statement(s) (VIS) given to me about the vaccine(s) the client is receiving today as noted below under "vaccines/services provided". I understand the vaccines given are based upon those recommended for the client's age, circumstances and/or available vaccine history. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) and their presently known side effects. There is no guarantee of immunity or that the client will not experience an adverse reaction to the vaccine(s). In the event of adverse side effects or that immunity does not occur, I hereby hold ELVPHD harmless for any and all liability to the extent permitted under the law. Vaccines administered by ELVPHD are entered into NESIIS (Nebraska State Immunization Information System). If applicable, I permit these services to be submitted to insurance. If the insurance does not pay, I understand that I am responsible for payment. ELVPHD provides Privacy Practices upon request from the client and this consent is considered the offer to provide ELVPHD's Privacy Practices. I have had a chance to ask questions about the Privacy Practices, and those questions have been answered to my satisfaction. I authorize ELVPHD to release information from the client's medical record including, but not limited to, the following entities: client family/guardians/representatives requesting the immunization record, child care, school or work-related authorities to prove immunization status, medical providers, medical records, billing and insurance. I authorize ELVPHD to photograph me and/or my child(ren) during the services provided and utilize the image(s) for publishing and/or distribution. ELVPHD will communicate with me regarding immunizations, other services or notification via text, email, phone or other electronic means and my signature indicates acceptance of those contacts until I revoke the authorization to ELVPHD in writing. I understand that the medical release may be revoked at any time by notifying ELVPHD in writing and the revocation will be effective as of the date notified except to the extent action has already been taken.

Vaccines/Services Provided: (to be completed by staff)

☐ DTap	☐ HPV	☐ Kinrix	☐ Pediarix	☐ Rotavirus	☐ COVID-19
☐ Hep A	☐ Infanrix	☐ Meningitis	☐ Pentacel	☐ Shingles	☐ Other: _____
☐ Hep B	☐ Influenza	☐ Meningitis B	☐ PCV 13	☐ Td/Tdap	
☐ Hib	☐ IPV	☐ MMR	☐ PPSV23	☐ Varicella	

This page to be completed by ELVPHD staff

Type of Flu Vaccine Given:

☐ Standard Fluarix **(Lot# NK45F)** – GSK, exp date 06/30/2022 - 0.5cc, IM
☐ Standard Fluarix (Lot#_____) – GSK, exp date - 0.5cc, IM
☐ HD Fluzone **(Lot #UJ731AB)** – SP, exp date 06/30/2022 0.5cc, IM
☐ HD Fluzone (Lot#_____) – SP, exp date 06/30/2022 0.5cc, IM
☐ VFC Flulaval **(Lot#3K9LY)**– exp date 6– 0.5cc, IM
☐ VFC Flulaval **(Lot# 2E43L)**– exp date– 0.5cc, IM
☐ AIP Flulaval **(Lot#3K9LY)**– exp date– 0.5cc, IM
☐ AIP Flulaval (Lot#_____)– exp date– 0.5cc, IM

Injection Site (circle):
Left Deltoid Right Deltoid
Other (specify):

Vaccine Type: | Lot #: | Exp Date:

Injection Site (circle one): Left Deltoid Right Deltoid
Other (specify) _____

Dosage: 0.5cc Route: IM
Other (specify) _____

Vaccine Type: | Lot #: | Exp Date:

Injection Site (circle one): Left Deltoid Right Deltoid
Other (specify) _____

Dosage: 0.5cc Route: IM
Other (specify) _____

Vaccine Type: | Lot #: | Exp Date:

Injection Site (circle one): Left Deltoid Right Deltoid
Other (specify) _____

Dosage: 0.5cc Route: IM
Other (specify) _____

Fill Out For COVID-19 Vaccine Administration:

Vaccine Type: | Lot #: | Exp Date:

Injection Site (circle one): Left Deltoid Right Deltoid
Other (specify) _____

Dosage: Route: IM
Other (specify) _____

☐ 1st dose ☐ 2nd dose ☐ 3rd dose ☐ Booster Dose

Nurse – for immunizations only:

_____ Signature of Vaccine Administrator

_____ Date of Service

For Private Pay Only:
Amount Paid: $_____
☐ Cash ☐ Check (#_____)

☐ NESIIS ☐ Imms Recall SS ☐ Billing/Tracking SS ☐ Insurance Billed