Flathead City County Health Department Consent

Last Name: _____ **M.I.** _____ **First Name:** _____ **Date of Birth:** _____/_____/_____

Maiden/Previous Name:_____ **Phone:** _____ **S.S.#**_____-_____-_____ **Age:** _____

Address: _____ **City/State:** _____ **Zip Code:** _____

Email:_____ **Gender:** _____ **Name of Emergency Contact:**_____

Phone:_____ **Circle all that apply – Race:** White Black/Afr Amer Asian Native Hi/Other PI Amer Ind/AK Native Other

Hispanic: Y N **Marital Status:** Single Married Divorced Widowed Separated **Student:** Y (FT PT) N **Employed:** FT PT Self Unemployed Retired

Preferred Contact Method: Mail TEXT/SMS Email Phone **Daycare:** Y N

PLEASE ANSWER THE FOLLOWING QUESTIONS FOR THE PERSON RECEIVING VACCINE:

Is the patient sick today? *If yes, list symptoms.*	**Yes**	**No**
Please list all allergies (e.g.: Latex, polyethylene glycol PEG, polysorbate):	**(NONE)**	
Has patient had any adverse reactions to previous vaccines? *If yes, list vaccines:*	**Yes**	**No**
Any medical condition such as Lung-Disease (e.g.: Asthma), HIV/AIDS, Cancer, Heart Disease, Kidney Disease, Metabolic Disease (e.g.: Diabetes), Brain/nervous system disorder (e.g.: seizures), blood disorder, immunosuppressive drugs, or therapies?	**Yes**	**No**
Does anyone else in the household?	**Yes**	**No**
Any medications or treatments such as hematopoietic cell transplant (HCT), CAR-T-cell therapies, cortisone, steroid type drugs, chemotherapy, radiation therapy, organ anti-rejection drugs or long-term aspirin therapy?	**Yes**	**No**
Does anyone else in the household?	**Yes**	**No**
History of Multisystem Inflammatory Syndrome (MIS-C or MIS-A), heparin-induced thrombocytopenia (HIT), thrombosis with thrombocytopenia syndrome (TTS), Guillain-Barre Syndrome (GBS), myocarditis or pericarditis, COVID-19 disease within the past 3 months?	**Yes**	**No**
If child is an infant, have they been diagnosed with Intussusception?	**Yes**	**No**
Any blood products in the past year, including immune globulin?	**Yes**	**No**
Is the patient pregnant?	**Yes**	**No**
Is the patient breastfeeding?	**Yes**	**No**
Has the patient received any vaccinations in the past 30 days?	**Yes**	**No**

TB Testing Questions
Reason for TB skin testing today:
Have you been tested previously for TB? **Yes (**Result:) **No Unknown**
Have you experienced any of the following: Check all that apply: ☐ Coughing up sputum or blood ☐ Fatigue/Tiredness Loss of appetite ☐ Fever or chills ☐ Unexplained weight loss ☐ Night sweats ☐ Prolonged coughing (longer than 3 weeks)

Emergency Use Authorization (EUA) Information: Flathead City-County Health Department is a Point of Dispensing (POD) organization in Montana for COVID-19 vaccine. There are 4 approved or authorized vaccines in the United States (Pfizer-BioNTech, Moderna, Novavax, and Johnson & Johnson's Janssen) granted emergency use authorization (EUA) by the Federal Drug Administration (FDA). On 08/23/21 the FDA approved Pfizer BioNTech COVID-19 for 16 years and older, and now marketed as Comirnaty, was approved for ages 12-15 on 7/8/22. On 01/31/22 the FDA approved Moderna COVID-19 vaccine for 18 years and older, and now marketed as Spikevax. No change was made to these vaccine's formula with their name change. Novavax, Janssen, Moderna (6 months-17 years), and Pfizer BioNTech (6 months-11 years) remains authorized by the FDA under EUA.

I have read or have had explained to me the information about the vaccine(s) being administered. I have received the Vaccine Information Statement (VIS) for each of the vaccines indicated. 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(s) and ask that the vaccine(s) be given to me or to the person named for whom I am authorized to make this request. I have had an opportunity to review the Flathead City-County Health Department Notice of Privacy Practices and receive an individual copy upon request. I have also been informed and understand that confidential health care information concerning me or the person for whom I am legally responsible, which may be provided to the Health Department or recorded while receiving immunization services, is electronically recorded, and retained in the Montana Public Health Data System (ImMTrax). I understand that if my insurance is billed, I am responsible to pay the co-payment, deductible payments and all charges for services not covered by my insurance plan.

Patient Signature		**Date**
Parent/Guardian Signature	**Relationship to Child/Patient**	**Initials**

Complete this section if you wish to authorize another adult to consent for immunizations for your child at this visit. You **MUST** provide a phone number. You will be called during the immunization appointment.			
I authorize (*print adult's name*)	to initial for consent for this child	Parent Phone:	
X	X		
Signature of parent or legal guardian	Signature of authorized adult	Initials	Date

☐ PRIVATE ☐ VFC (18↓) ☐ STATE (19↑) STOP TO PAY ☐ YES ☐ NO

FOR CLINIC USE ONLY: ☐ No White Card ☐ No ECW Record ☐ No ImMTrax ☐ No Other Record **LOCKED** ☐

	Auth. Initial	Vaccine Type	Dose #	Brand	ICD-10	Lot #	Rt	Site	Nurse Initials	PVT $	VFC $	STATE $
DATE		LAB		RESULTS Email Mail Pick-up Hardcopy	Voicemail Yes No							
		DTAP		Infanrix	Z23		IM					
		DTaP-IPV-HepB-HIB		Vaxelis	Z23		IM					
		DTaP-IPV-HepB		Pediarix	Z23		IM					
		DTaP-IPV		Kinrix	Z23		IM					
		Hepatitis A 0.5 / 1.0		Havrix	Z23		IM					
		Hepatitis A and B		Twinrix	Z23		IM					
		Hepatitis B 0.5 / 1.0		Heplisav-B / Energix-B	Z23		IM					
		HIB		ActHib / Pedvax	Z23		IM					
AGE		HPV 9		Gardasil 9	Z23		IM					
		IPV		Poliovirus	Z23		IM SQ					
BIRTH DATE		MMR		MMR	Z23		SQ					
		MMRV		ProQuad	Z23		SQ					
		MCV4 (MenACWY)		Menveo / MenQuadfi	Z23		IM					
		MenB		Bexsero	Z23		IM					
		PPSV23		Pneumovax	Z23		IM					
		PCV13		Prevnar	Z23		IM					
MI		PCV20		Prevnar20	Z23		IM					
		Rotavirus		Rotateq	Z23		PO					
		Shingles		Shingrix	Z23		IM					
		Td		Tenivac / GRF	Z23		IM					
FIRST NAME		Tdap		Boostrix	Z23		IM					
		Varicella		Varivax	Z23		SQ					
		Rabies		Raba Vert / Immovax	Z23		IM					
		Flu Seasonal		Influenza	Z23		IM					
		Flu Mist		Flu Mist	Z23		Nasal					
		Cholera		Vaxchora	Z23		SQ					
LAST NAME		Japanese Encephalitis		IXIARO	Z23		IM					
		Typhoid IM		Typhim Vi	Z23		IM					
		Typhoid Oral		Vivotif	Z23		PO					
		Yellow Fever		YF-VAX	Z23		SQ					
		Travelers Diarrhea Rx										
		Malaria Rx										
		International Certificate PHN02										
		Travel Consult: (circle) Limited 99402 Basic 99403 Extended 99404										

	PPD TB test		Tubersol	Z11.1				ID					
Given	Date	Time	Read	Date	Time	Result	mm	Neg	Pos	Nurse Intials			

Unaccompanied minor	*Vaccine admin time:*	*Nurse initial*	*Clinic exit time:*
Telephone Verification	*Parent/Guardian Name*	*Nurse Initial*	*Date* *Time*

Insurance Name	Subscriber ID #	Group #

Cash _____Check _____Credit Card _____Voucher_____VFC _____Total_____