Delaware General Health District
Adult Vaccine Consent Form

PLEASE PRINT CLEARLY

Delaware General Health District
Dedicated to your health

Nurse Use Only

IMPACT _____
NN _____

First Name: Middle Initial:

Last Name:

Address:

City: State: Zip:

Phone: - - Birthdate: Gender:

Home Cell Work (please circle one) M M D D Y Y Y Y

OPTIONAL DEMOGRAPHICS (please circle)

Race: White/Caucasian Black/African American Native Hawaiian Alaska Native Asian American Indian Other

Ethnicity: Hispanic/Latino NOT Hispanic/Latino Other Preferred Language:_____

Primary Insurance Company: _____ **Name of Primary Insured:**_____

Member ID:_____

Primary Insured Birthdate:_____ **Relationship to Primary Insured:**_____

Address of Primary Insured (if different from patient)**:**_____

Secondary Insurance Company: _____ Name of Primary Insured:_____

Member ID:_____

Primary Insured Birthdate:_____ Relationship to Primary Insured:_____

Address of Primary Insured (if different from patient):_____

IF NO INSURANCE, PLEASE COMPLETE THE FOLLOWING TO REQUEST DISCOUNTED SERVICES:

"I state that there are _____ number of people living in my household
and the combined household income is $_____ per week / month / year" (circle one)

Responsible Party
(if other than self):
Relationship to Patient:

Address:

City: State: Zip:

Phone: - - Home Cell Work (please circle one)

The clinic will keep this form for 10 years. It will include information on what vaccine(s) were given, when the vaccine(s)/tooth varnish were provided, the name of the company that made the vaccine(s), and the vaccine's lot number. Also, on record will be the name and address of where the vaccine(s) was given, name & title of the Nurse who gave the vaccine(s), and the publication date of your Vaccine Information Statement(s). "I have read or have had explained to me the information in the Vaccine Information Statement(s) for the immunization(s) given and/or Tooth Varnish information today. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of these vaccines and ask that the vaccine(s) requested be given to me or to the person named below for whom I am authorized to make this request. I understand that this information will be released to a state-wide Immunization Registry for the purpose of immunization tracking, recall and recording, unless I request otherwise. I have received the DGHD Notice of Privacy Practices regarding the uses and disclosures of the health information for me and/or my child. I authorize my insurance company to assign the amount payable directly to DGHD. I understand that I am financially responsible for all the charges that are not covered .

Patient Signature:_____ Date:_____

OFFICE USE ONLY: Ins.____ Cash____ MERCK____ State____ Medicaid____ Medicare____ Transact RX____
(Insurance Verified_____) Admin. Asst.: ___NN ___Impact

STOP — For Office Use Only

Vaccine Administration Record

Client Return Date_____

VACCINE	DOSE #	MFG	LOT #	SITE	VIS Provided	SCREENED/ COUNSELED	SIGNATURE and TITLE	DATE
GARDASIL 9 pvt. merck 90651		MERCK		LD RD IM	04/15/15	Y N		
HEP A pvt. state merck 90632		GSK/ MERCK		LD RD IM	10/25/11	Y N		
HEP B pvt. state merck 90746		GSK/ MERCK		LD RD IM	02/02/12 10/22/14	Y N		
IPV (Polio) 90713		SP		LD RD SQ IM	11/08/11 10/22/14	Y N		
MENINGOCOCCAL 90734		SP		LD RD IM	10/14/11	Y N		
MMR pvt. state merck 90707		MERCK		LA RA SQ	04/20/12	Y N		
PNEUMOCOCCAL pvt. state merck 90732		MERCK		LD RD IM	04/24/15	Y N		
PREVNAR-13 state pfizer 90670		WYETH/ PFIZER		LD RD IM	11/05/15	Y N		
RABIES 90675		SP		LD RD IM	10/06/09	Y N		
SHINGLES pvt. merck 90736		MERCK		LA RA SQ	10/06/09	Y N		
TDAP 90715 pvt. state americares		SP GSK		LD RD IM	02/24/15	Y N		
TD state 90714		SP		LD RD IM	02/04/14	Y N		
TWINRIX state 90636		GSK		LD RD IM	10/25/11 02/02/12	Y N		
VARICELLA pvt. merck 90716		MERCK		LA RA SQ	03/13/08	Y N		
Nursing Assessment 99211	Notes:							

CHOLESTEROL 82465	CHOLESTECH 80061QW	FINGERSTICK 36416	HbA1C 83037	HEMOGLOBIN 85018
BLOOD GLUCOSE 82962	DILUENT			