Delaware General Health District
Dedicated to Your Health

Adult Consent Form

Please Print Clearly

First Name _____ MI _____ Last Name _____ Gender _____ Age _____

Address _____ City _____ State _____ Zip code _____

Phone: _____ Email: _____ Birthdate: ____ (Month) ____ (Day) ____ (Year)

Race : _____ Ethnicity (Please circle one) : Hispanic/ Latino Not Hispanic/Latino Preferred Language : _____

Insurance Company _____ Member ID _____ Group # _____

Claim Submission Address _____ Social Security # _____

Primary Insured Name _____ Birthdate _____ Relationship to Patient _____

Address (If different from patient _____

Secondary Insurance Company _____ Member ID _____ Group # _____

Claim Submission Address _____ Social Security # _____

Primary Insured Name _____ Birthdate _____ Relationship to Patient _____

Address (If different from patient _____

NO INSURANCE	Household Size:		Household Income:		Per Week/Month/Year

Please Answer the following Questions	Yes	No
Are you sick today?		
Do you have allergies to medications, food, a vaccine component, or latex?		
Have you ever had a serious reaction after receiving a vaccination?		
Do you have a long-term health problem with heart, lung, kidney, neurologic, liver, or metabolic disease (e.g., diabetes), asthma, or a blood disorder?		
Do you have cancer, leukemia, HIV/AIDS, or any other immune system problems; or in the past 3 months, have you taken medications that affect the immune system such as prednisone, other steroids, long-term aspirin therapy, anti-viral drugs, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?		
Have you had a seizure or a brain or other nervous system problem? (Guillain Barre Syndrome)		
Do you live with or have close contact with someone who is in protective isolation (e.g. bone marrow transplant unit) ?		
Have you received vaccinations in the past 4 weeks?		
For Females: Are you pregnant or is there a chance you could become pregnant during the next month?		

The Delaware General Health District may keep this record in my medical file. DGHD will record what vaccine was given, the date the vaccine was given, the name of the company that made the vaccine, the vaccine lot number, the signature and title of the person who gave the vaccine, and the address where the vaccine was given. 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 read or have had explained to me the information sheet about the vaccine. I have had a chance to ask questions, and they were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and ask that the vaccine be given to the person named above for whom I am authorized to make this request. My medical information will not be shared without an authorization to release information. A copy of the Health Districts Notice of Privacy Practices (HIPAA) will be provided and is also located on our website at delawarehealth.org.

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 under my private insurance plan**. I acknowledge that any co-payment is due and payable on the date services are received.

Patient Signature: _____ **Date:** _____

OFFICE USE ONLY

☐ Tdap	☐ TD	☐ Polio	☐ Hep B	☐ Pneumococcal	☐ Prevnar 13	☐ Shingles	☐ Flu Shot
☐ HPV	☐ Hep A	☐ Rabies	☐ Meningococcal B	☐ Meningococcal ACWY	☐ MMR	☐ Varicella	☐ Flu Mist

STOP — For Office Use Only

Vaccine Administration Record

VACCINE	DOSE #	LOT #	SITE	SIGNATURE and TITLE	DATE
GARDASIL 9 90651			LD RD IM		
HEP A 90632			LD RD IM		
HEP B 90746			LD RD IM		
IPV (POLIO) 90713			LD RD SQ IM		
MENINGOCOCCAL ACWY 90734			LD RD IM		
MMR 90707			LA RA SQ		
PNEUMOCOCCAL 90732			LD RD IM		
PREVNAR-13 90670			LD RD IM		
RABIES 90675			LD RD IM		
SHINGLES 90750			LD RD IM		
TDAP 90715			LD RD IM		
TD 90714			LD RD IM		
VARICELLA 90716			LA RA SQ		
MENINGOCOCCAL B 90620			LD RD IM		
High Dose Flu 90662			LVL RVL LD RD IM		
Flu Pres. free 90686			LVL RVL LD RD IM		
FluBlok Egg Free 90673			LVL RVL LD RD IM		
FluMist 90672			Nasal		
Nursing Assessment 99211	Notes:				

Administrative Assistant	
Time In	
NN Number	
Insurance Verified	
Primary Insurance	
State	Private
NN Completed	
Impact Completed	
Nurse	
Time Completed	
NN Completed	
Impact Completed	

Doctor Information	
☐ Notification of Vaccination Form Filled Out	
Last Well Visit	