Delaware Public Health District
Dedicated to your health

Adult Consent Form

First Name: _____ MI: ____ Last Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____Email: _____ Birthdate: _____ Age: _____

Race: _____ Preferred Language:_____ **Sex** [ ] Male [ ]Female **Hispanic/Latino?** [ ] Yes [ ]No

Please Answer the Following Questions:	Yes	No	Not Sure
1. Are you sick today?			
2. Do you have allergies to medications, food, a vaccine component, or latex?			
3. Have you ever had a serious reaction after receiving a vaccine?			
4. Do you have any of the following: a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak? Are you on long-term aspirin therapy?			
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?			
6. Do you have a parent, brother, or sister with an immune system problem?			
7. In the past 6 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?			
8. Have you had a seizure or a brain or other nervous system problem?			
9. Have you ever been diagnosed with a heart condition (myocarditis or pericarditis) or have you had Multisystem Inflammatory Syndrome (MIS-A or MIS-C) after an infection with the virus that causes COVID-19?			
10. In the past year, have you received immune (gamma) globulin, blood/blood products, or an antiviral drug?			
11. Are you pregnant?			
12. Have you received any vaccinations in the past 4 weeks?			
13. Have you ever felt dizzy or faint before, during, or after a shot?			
14. Are you anxious about getting a shot today?			
Questions 15-21 for TB Testing ONLY:	**Yes**	**No**	**Not Sure**
15. Have you ever had a TB skin test before?			
16. Have you ever had a positive TB skin test?			
17. Have you ever been diagnosed with TB?			
18. Have you ever been told not to have a TB skin test?			
19. Have you been asked to come in for a test because someone you know has been diagnosed with TB?			
20. Have you had BCG vaccination before?			
21. Do you need a 2-step TB skin test? (2 tests performed within 1-3 weeks; Some health care workers need this)			

Are you the insurance subscriber/policyholder? [ ] Yes [ ] No *if no, please complete subscriber's information below*

Insurance Subscriber's First and Last Name: _____ **Sex** [ ] Male [ ]Female

Insurance Subscriber's Date of Birth: _____ Relationship to Patient:_____

Address (if different than patient): _____

If you do not have insurance, please answer the following:

Household Size:_____Household income:_____Frequency of income: [ ] per week [ ] per month [ ] per year

The Delaware Public Health District may keep this record in the patient's medical file. DPHD will record what vaccine or service was given, the date the vaccine or service 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 and any screening or service provided with date and person providing the service. 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 understand that this information will be released and received from a healthcare provider interoperability Hub (e.g. carequality/ commonwell) for the purpose of sharing and providing patient care, unless I request otherwise. I understand that appointment, cancellation, and reminder information will come to me through email, phone call, and/or text, unless I request otherwise. I understand these permissions will be valid until revoked. For TB: The clinic will keep this form for seven years if result is negative and permanently if the result is positive. It will include information when TB test was given, PPD lot #, result and name and address of where the test was given.

I have read or have had explained to me the information sheet about the vaccine, TB test, or service to be received today. 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 or service and ask that the vaccine or service be given to the person named above for whom I am authorized to make this request. Except as outlined above and in the notice of privacy practices, my medical information will not be shared without an authorization to release information. I have received the Health District's Notice of Privacy Practices (HIPAA) and it is also located on our website at delawarehealth.org. I authorize my insurance company to assign the amount payable directly to DPHD. I understand that I am financially responsible for all the charges that are not covered under my insurance plan or elective service. I acknowledge that any co-payment is due and payable on the date services are received.

Patient Signature: _____Date:_____

VACCINE	CPT	Route	Dose #	Lot #	SITE	
Chikungunya-IXCHIQ	90589	IM			LD RD	LVL RVL
Cholera- Vaxchora	90625	PO			Mouth	
COVID-19 –Moderna Monov 12+	91322	IM			LD RD	LVL RVL
Flu Pres. Free – Fluzone 6m+ PFS Fluarix	90686	IM			LD RD	LVL RVL
Flu (ccIIV4)- Flucelvax 6mo PFS	90674	IM			LD RD	LVL RVL
High Dose Flu – Fluzone High Dose-PRV	90662	IM			LD RD	
FluMist	90672	Nasal			Nasal	
HepA- Adult 1.0ml– Vaqta Adult	90632	IM			LD RD	LVL RVL
HepB- Adult 1.0ml (3 dose_ Engerix-B Adult PFS Recombivax HB Adult PFS	90746	IM			LD RD	LVL RVL
HepB 2 dose - Heplisav B	90739	IM			LD RD	LVL RVL
HIB - ActHIB	90648	IM			LD RD	LVL RVL
HPV - GARDASIL 9	90651	IM			LD RD	LVL RVL
IPV - IPOL	90713	SQ / IM			LD RD LA RA	LVL RVL LT RT
JE –VC (IXIARO) – Japanese Encephalitis	90738	IM			LD RD	LVL RVL
MENINGOCOCCAL ACWY - MenQuadfi	90619	IM			LD RD	LVL RVL
MENINGOCOCCAL B - Bexsero	90620	IM			LD RD	LVL RVL
MMR- MMRII	90707	SQ			LA RA	LT RT
PREVNAR 20	90677	IM			LD RD	LVL RVL
PNEUMOCOCCAL CONJ 15- Vaxneuvance	90671	IM			LD RD	LVL RVL
PNEUMO 23 – Pneumovax23	90732	SQ / IM			LD RD LA RA	
RABIES - Imovax	90675	IM			LD RD	LVL RVL
RSV- Adult - Arexvy	90679	IM			LD RD	
SHINGLES – Shingrix	90750	IM			LD RD	
TDAP- Adacel	90715	IM			LD RD	
Typhoid – Typhim Vi	90691	IM			LD RD	LVL RVL
VARICELLA - Varivax	90716	SQ			LA RA	
Yellow Fever	90717	SQ			LA RA	LT RT

TB Step 1	Placed:	RN:	Read:	RN:	Assess: mm	Result: + / -	Lot #:	LFA RFA
TB Step 2	Placed:	RN:	Read:	RN:	Assess: mm	Result: + / -	Lot #:	LFA RFA

Vaccine Administrator Signature: _____ Date: _____

Admin

Delaware [ ] Other location:_____ State [ ] Private [ ] Insurance Verified or % on Sliding Fee: _____

Primary Pay Source:_____Member ID: _____

Secondary Pay Source: _____ Member ID: _____

eCW Chart created: _____ Scanned into eCW:_____

For TB-

Paid for Step 1 (initial) _____

Paid for Step 2 (initial) _____

For TB-

Bill to employer: LF invoice made: _____ Date: _____ LF invoice paid:_____ Date: _____

Nurse

ImpactSIIS Status: ACTIVE / INACTIVE

eCW charting completed: _____

Notes:

Sign In:_____ Admin completed:_____ RN received:_____ RN completed:_____