

MONMOUTH COUNTY REGIONAL HEALTH COMMISSION NO. 1

INFORMED CONSENT FOR RECEIPT OF VACCINE(S)—ADULTS

- | | Please Circle | | |
|---|----------------------|----|------------|
| 1. Are you sick today OR on antibiotics? | Yes | No | Don't Know |
| 2. Do you have allergies to medications, food, a vaccine component, or latex? | Yes | No | Don't Know |
| 3. Have you ever had a serious reaction after receiving a vaccination? | Yes | No | Don't know |
| 4. Do you have a long-term problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder? | Yes | No | Don't Know |
| 5. Do you have cancer, leukemia, AIDS, or any other immune system problem? | Yes | No | Don't Know |
| 6. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments? | Yes | No | Don't Know |
| 7. Have you had a seizure, a brain or other nervous system problem? | Yes | No | Don't Know |
| 8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? | Yes | No | Don't Know |
| 9. For women: Are you pregnant or is there a chance you could become pregnant during the next month? | Yes | No | Don't Know |
| 10. Have you received any vaccinations in the past 4 weeks? | Yes | No | Don't Know |
| 11. Are you taking Coumadin or any other prescription blood thinning medicine? | Yes* | No | Don't Know |

I've read or had explained to me the information about _____ disease(s), the vaccine(s), and special precautions. I've had an opportunity to ask questions about the specific vaccine(s) which were answered to my satisfaction and I hereby certify that I am 18 years of age or older.

To my knowledge either I or the person I am authorized to make the request for is not allergic to epinephrine (adrenaline) or Benadryl (diphenhydramine) – drugs used to counteract an allergic reaction. If I am taking coumadin or another prescription blood thinner, I have completed the screening survey.

I understand that MCRHC does not accept any Commercial insurances. I hereby acknowledge that I had the opportunity to receive the federal HIPAA notice of privacy information sheet, along with the Vaccine Information Statement(s) for the vaccine(s) I will be receiving.

I believe I understand the benefits and risks of the vaccine(s) and I consent that it (they) be given to me or to the person named below of whom I am the guardian or authorized person. I also permit data to be entered into the NJIIS immunization registry.

Signature: _____ **Date:** _____
Person receiving vaccine(s) or Medicare Part B beneficiary

Last Name: _____	First Name: _____	MI: _____
Address: _____	City: _____	State: _____ Zip: _____
Phone#: () _____	Birth Date: ____/____/____	Sex: M or F Age: _____
Part B Medicare #: _____ A-B-C-D or Medicaid #: _____		
Payment Amount: _____ Cash/Check		

Vaccine: _____	Lot #: _____	Manufacturer: _____	Exp.: _____
Date on VIS: _____	Site of Injection: left arm () right arm ()		Date Vaccine & VIS Given: _____
Signature of Nurse who administered: _____			VFC ARRA MCRHC

Vaccine: _____	Lot #: _____	Manufacturer: _____	Exp.: _____
Date on VIS: _____	Site of Injection: left arm () right arm ()		Date Vaccine & VIS Given: _____
Signature of Nurse who administered: _____			VFC ARRA MCRHC

Next appointment date (if needed): _____

NJIIS Registry ID: _____