Patient Information and Consent Form

PATIENT INFORMATION

Last Name	First	MI	Birth Date

Address	Apt#	City	State	Zip

Parent/Guardian Name:	Home Phone:
Household Monthly Income (Gross):	Number of Members in Household:

Please Answer the Following Questions <u>About the Person</u> Who is Receiving Immunizations

Translator Preferred? ☐ Yes ☐ No

Language spoken at home:

☐ English ☐ Spanish ☐ Punjabi ☐ Other _____

Ethnicity

☐ Hispanic ☐ Non-Hispanic

Race

☐ White ☐ Asian ☐ Black/African American
☐ American Indian/Alaska Native
☐ Hawaiian/Pacific Islander ☐ 2 or more races
☐ Other _____

What sex was patient assigned at birth?

☐ Female ☐ Male ☐ Non-binary ☐ Intersex
☐ Don't know ☐ Prefer not to answer

Which of the following best reflects how the patient identifies?

☐ Heterosexual or straight ☐ Bisexual
☐ Gay, Lesbian or Same-Gender
☐ Questioning or unsure ☐ Declined to Answer
☐ Orientation not listed

What is the patient's current gender identity?

☐ Female ☐ Trans Female/Trans Woman
☐ Male ☐ Trans Male/Trans Man
☐ Genderqueer or non-binary ☐ Identity not listed
☐ Declined to answer ☐ Unknown

Health Insurance Status

☐ **Medi-Cal** ☐ **Medi-Care** ☐ **Private Insurance** ☐ **Other Public Insurance** ☐ **No Insurance**

Does patient have a healthcare provider (i.e. Medical Doctor, Nurse Practitioner, etc.)?

☐ **Yes** ☐ **No** ☐ **Unsure**

	YES	NO
1. Are you sick today?		
2. Have you ever had a serious reaction after receiving a vaccination?		
3. Do you have allergies to medications, food, a vaccine ingredient, or latex?		
4. If the vaccination is for a child 2 to 4 years of age, has a healthcare provider told you that the child had wheezing or asthma?		
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?		
6. Have you, a sibling or a parent had a seizure, a brain disorder, or a nervous system problem?		
7. Have you had a long- term health problem with lung, heart, kidney or metabolic disease (e.g. diabetes), asthma, anemia, Guillain-Barre Syndrome, or other blood disorders?		
8. If the vaccination is for a child, is he/she on long-term aspirin therapy?		
9. If the vaccination is for a baby, have you ever been told he/she has had intussusception (intestinal condition)?		
10. In the past 3 months, have you taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatment?		
11. In the past year, have you received a transfusion of blood or blood products, or been given immune globulin or antivirals?		
12 If applicable, are you pregnant or is there a chance could become pregnant in the next month?		
13. Have you received vaccinations in the past 4 weeks?		

Read Carefully and Sign: To the best of my knowledge, the above statements are true and complete. I have been given a copy and have read, or have had explained to me, the information contained in the Vaccine Information Statement(s) about the disease(s) and vaccine(s) indicated below. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) indicated below be given to me or to the person named above for whom I am authorized to make this request.

I have been informed to wait 20 minutes in clinic after immunization(s) has/have been administered to make sure there are no adverse reactions to the vaccine.

Sign below if 18 or older. If person to receive vaccine is under 18, parent or legal guardian must sign below.

Signature of responsible party	Print name of responsible party	Date
_____	_____	_____

For Office Use Only

VFC 317 SGF PVT

Registry # _____

Has client or responsible party been disclosed of intent to submit Immunization information to CAIR? ☐ Yes ☐ No

Has client or responsible party agreed to share immunization information in CAIR with other providers, agencies, and schools? ☐ Yes ☐ No

SITE	VACCINE	MANUFACTURER	LOT #	DOSE	VIS DATE	FEE RECEIVED
RL LL RA LA SQ IM						
RL LL RA LA SQ IM						
RL LL RA LA SQ IM						
RL LL RA LA SQ IM						
RL LL RA LA SQ IM						
RL LL RA LA SQ IM						
RL LL RA LA SQ IM						
RL LL RA LA SQ IM						

Services Provided By: _____

Signature of Nurse Administering Immunization(s): _____ Date: _____