SAGINAW COUNTY HEALTH DEPARTMENT
PERSONAL AND PREVENTIVE HEALTH SERVICES
ADULT IMMUNIZATION CONSENT FORM
19 YEARS AND OLDER

MI-AVP _____
VOUCHER_____
INS/SELF PAY____
INS INFO GIVEN

PLEASE PRINT **DATE OF BIRTH**

Client's LEGAL Name:_____ _____/_____/_____
Last First Full Middle Maiden Name/ALIAS Month Day Year

Client's Address:_____ **AGE** _____
House Number Street City ZIP Township

Parent/Guardian's Name:_____ **Phone:** (989) _____-_____

Please Check if you are one of the following: American Indian ☐ Alaskan Native ☐ **Sex** M F

What type of health insurance do you have? **None** ☐ **BCBS** ☐ **BCN** ☐ **HAP** ☐ **Priority Health** ☐
Medicare/Medicare Part D ☐ **Medicaid** ☐ HMO_____ **Other**?_____
Does your insurance cover any part of immunizations? YES ☐ NO ☐

PLEASE ANSWER THE FOLLOWING QUESTIONS:	**YES**	**NO**
1. Are you sick today?		
2. Are you on any medication?		
3. Do you have allergies to medications, food or any vaccine, including latex, eggs or thimerosal?		
4. Have you ever had a serious reaction after receiving a vaccination, including the flu shot in the past?		
5. Have you ever had a seizure or a brain problem?		
6. Have you ever had the chicken pox disease? If so, what age? _____		
7. Do you have cancer, leukemia, AIDS, or any other immune system problem?		
8. Have you ever been diagnosed with Guillain-Barre' Syndrome? (nerve disorder)		
9. Do you have a blood disorder or are you taking a blood thinner medication?		
10. Do you take cortisone, prednisone, other steroids, or anti-cancer drugs or have you had any x-ray treatments?		
11. During the past year, have you received a transfusion of blood or blood products, or been given medicine called immune (gamma) globulin?		
12. For **women**: Are you pregnant or is there a chance you could become pregnant during the next month? **Date of last menstrual period** _____		
13. Have you received any vaccinations in the past 4 weeks, including the flu vaccine?		

SCHD STAFF USE ONLY
Diagnosis Code – Z23

___ **Hep A** 90632
___ **Hep B** (Ped/Adol) 90744
___ **Hep B** (Adult) 90746
___ **HPV9** 90651
___ **IIV4 PF** (3 yr+) 90686
___ **IPV** 90713
___ **Meningococcal B** (Bexsero) 90620
___ **Meningococcal B** (Trumenba) 90621
___ **MPSV4** 90733
___ **MCV4** 90734
___ **MMR** 90707
___ **Pneumococcal** 90732
___ **Prevnar** (PCV-13) 90670
___ **Shingrix** (90750)
___ **TB SKIN TEST** 86580-Z11.1
___ **Tdap** 90715
___ **TD-PF** 90714
___ **Varivax** 90716

Administration Fee
___ 90471 ___ 90472
___ G0008**(Medicare Flu)** ___ G0009**(Medicare Pneumonia)**

Nurse Signature

I have received and read the Vaccine Information Statements and have had my questions answered, and read the PRIVACY NOTICE informing me of my privacy rights and Health Department responsibilities. Vaccinations given and recorded on the clinic record can be released to the Michigan Care Improvement Registry (MCIR) and my insurance plan, if applicable. I acknowledge that I have received the vaccine(s) indicated and all information above is accurate. I authorize the Health Department to bill and collect from my insurance for the vaccine(s) and related administration fee(s). **I understand that I am responsible for required copayments or deductibles and any other costs associated with vaccination that are not covered by my insurance plan.**

_____ _____
Signature of the Client, Parent or Guardian **Today's date**