Parker County Hospital District Outreach

ADULT Vaccine Consent Form

1115 Pecan Drive Weatherford, Texas 76086
www.pchdtx.gov (817) 458 - 3254

Patient's Name: ______________________________ **Today's Date:** ___/_____/__________
Patient's Birth Date: ___/_____/______ **Patient's Age:** ______ **Gender: (M / F)** **Phone:** ________________
Address: ______________________________ **City / Zip:** ______________________________

REQUIRED INSURANCE INFORMATON

By completing the following insurance section, I authorize payment of medical benefits for any services provided. This information will be used for the purpose of evaluating and administering claims of benefits.

Please indicate the patient's coverage provider:

☐ Aetna ☐ Blue Cross Blue Shield ☐ CIGNA ☐ Humana ☐ United

Subscriber (Policy Holder) Name:	Member ID (All letters & numbers):
Subscriber (Policy Holder) DOB: ____/____/____	Group #:

*** If you are filing insurance, please include a copy of your card with this consent form**

TRICARE Military Member's Information:	Policy Holder Name:	DOB:	SS#:	DOD #:
		____/___/____	____________	____________

Please answer the following questions about the patient receiving the immunization(s) today:

1. Is the patient sick today? Yes____ No____
2. Does the patient have allergies to medications, food, or any vaccine component, or latex? Yes____ No____
   **IF yes, describe________________________________
3. Has the patient had a serious reaction to a vaccine in the past? Yes____ No____
   **IF yes, describe________________________________
4. Has the patient ever felt dizzy or faint before, during or after receiving a shot? Yes____ No____
5. Has the patient or an immediate family member had a seizure; has the patient had brain or other nervous system problems? Yes____ No____
   **IF yes, describe________________________________
6. Does the patient have cancer, leukemia, HIV/AIDS, or any other immune system problem? Yes____ No____
   **IF yes, describe________________________________
7. Does the patient have a parent or sibling with an immune system problem? Yes____ No____
   **IF yes, describe________________________________
8. In the past 6 months, has the patient taken medications that affect the immune system such as cortisone, prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments? Yes____ No____
   If yes list medication and date of last treatment ________________________________
9. Has the patient received transfusion of blood or blood products, or been given immune (gamma) gobulin or an antiviral drug in the past year? Yes____ No____
   **IF yes, describe________________________________
10. Does the patient have a blood or bleeding disorder such as thrombocytopenia or thrombocytopenia purpura? Yes____ No____
11. (If 20 years or younger) Is the patient on aspirin therapy? Yes____ No____
12. Is the patient pregnant or could become pregnant in the next month? Yes____ No____
13. Has the patient received a vaccination in the past 4 weeks? Yes____ No____
    **IF yes, please list vaccine(s)________________________________

Consent for Immunization

I hereby give authorization for PCHD to administer required vaccinations to myself. I release Parker County Hospital District, its employees, representatives and agents from any liability for giving myself/child vaccinations. I accept responsibility for seeking medical attention for any problems associated with receiving the vaccines. I am also aware that the receiver of this vaccine is currently not pregnant and should not become pregnant within 4 weeks of receiving certain live virus vaccines. I acknowledge that I have received all vaccine information sheets, via QR code, for the vaccines given. I have had the opportunity to have all my questions answered. I understand that this consent is valid for 6 months and I will make PCHD aware of any changes prior to being vaccinated.

Scan this QR code with your phone to access information about the vaccine(s) to be given.

Patient Signature: ________________________________ **Date:**____/____/__________

PCHD Staff signature:________________________________ Date:____/____/__________