

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

REQUIRED INSURANCE INFORMATION

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) globulin 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:** ___/___/___

