Southwest District Health

Adult Questionnaire and Consent

Print Client Name: _____ DOB:_____ Age: ____

Gender: Male/Female Telephone Number: _____

Responsible Party (Print): _____

Address: _____ City _____ State _____ Zip_____

Race (circle one) White Black Native American Asian Pacific Islander Other **Hispanic/Latino**: Yes/No

Answer Following questions only if you are covered by health insurance:

Name of Insurance Company_____ Group #_____

Name of Insured (person who has policy) _____Insured's ID#_____

Insured's Date of Birth_____ Male/Female Insurance Address_____

		Yes	No	Don't Know
1.	Are you sick today?	☐	☐	☐
2.	Do you have an allergy to medications, food, a vaccine component or latex?	☐	☐	☐
3.	Have you ever had a serious reaction after receiving a vaccination?	☐	☐	☐
4.	Do you have any long-term health problem with heart, lung, kidney, liver, metabolic disease (e.g., diabetes), asthma or blood disorder?	☐	☐	☐
5.	Do you have cancer, HIV/AIDS, or any other immune system problem; or, in the past 3 months, have you taken medications that weaken the immune system, such as cortisone, prednisone, other steroids, or anticancer drugs; or had radiation treatments?	☐	☐	☐
6.	Have you had a seizure, or other nervous system problem?	☐	☐	☐
7.	In the past year, have you received a transfusion of blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
8.	Are you on a long term aspirin therapy or a blood thinner?	☐	☐	☐
9.	Are you pregnant or could become pregnant in the next three months?	☐	☐	☐
10.	Have you ever had Guillain-Barré syndrome?	☐	☐	☐
11.	Do you live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation?	☐	☐	☐
12.	Have you received any vaccinations in the past four weeks?	☐	☐	☐

I have reviewed and answered the questions above to the best of my ability. I have been given a copy and reviewed the Vaccine Information Statement(s). I have had a chance to ask questions and they were answered to my satisfaction. I understand the benefits and risks of the recommended vaccines. I ask that the recommended vaccines be given to me or to the person named for whom I am authorized to make this request and consent. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the provider of any changes in my medical status. I also authorize the healthcare staff to perform the necessary health care services I may need today. My immunization record will be entered into the Idaho Immunization Reminder System (IRIS). Participation in IRIS is voluntary and I may opt out at any time by contacting the Idaho Immunization Program.

I have been given the opportunity to review the HIPAA Disclosure. A copy can be provided to me at my request.

Payment is expected at the time of service. SWDH will bill your insurance; you will be responsible for any remaining balance.

For your health and safety, please remain in the designated waiting area 15 minutes after your visit.

Client Signature: _____ Date: _____

==========**Office Use Only**==========

VIS Statement(s) Provided:

Hep A ____ Hep B ____ HPV ____ IPV ____ MCV4 ____
Zoster ____ Flu ____ Tdap ____ Men B____ MMR ____

==========**Nurse Use Only**==========

Nurse counseled client / parent / guardian and answered questions regarding:

Hep A ____ Hep B ____ HPV ____ IPV ____ MCV4 ____ MMR ____
Men B ____ Twinrix ____ Tdap ____ VZV/RZV ____ Flu ____ Var ____

Final Screener:_____ Vaccinator:_____ Date:_____

Notes:_____

_____