Hancock Public Health

Your Recognized Leader in Population Health

Lindsay Summit, MPH, Health Commissioner

SECTION 1: PATIENT INFORMATION (PLEASE PRINT)

Name: Last: _____ First: _____ MI: ___ **Date of Birth:** Month: _____ Day: _____ Year: _____ **Age:** _____
Phone Number: _____ **Address:** _____ **APT/Room #:** _____
City: _____ **State:** _____ **ZIP Code:** _____
Sex: ☐ Male ☐ Female **Race:** _____ **Ethnicity:** ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Declined to Specify

SECTION 2: PATIENT INSURANCE INFORMATION

Primary Insurance ID#: _____
Grp#: _____ **Insurance Co:** _____
Insurance Co. Address: _____
Ins Co. Phone #: _____ **Insured's Name:** _____
Insured's DOB: _____ **Relationship to Patient:** _____

Secondary Insurance ID#: _____
Grp#: _____ **Insurance Co:** _____
Insurance Co. Address: _____
Ins Co. Phone #: _____ **Insured's Name:** _____
Insured's DOB: _____ **Relationship to Patient:** _____

SECTION 3: SCREENING QUESTIONS FOR CONTRAINDICATIONS TO VACCINES (Check YES or NO)

***You only need to fill out the questionnaires for the vaccines that you would like to receive today.**

Influenza Vaccine Screening Questions

1. Is the person to be vaccinated sick today? ☐YES ☐NO
2. Does the person to be vaccinated have an allergy to an ingredient of the vaccine? ☐YES ☐NO
3. Has the person to be vaccinated ever had a serious reaction to an influenza vaccine in the past? ☐YES ☐NO
4. Has the person to be vaccinated ever had Guillain Barre syndrome? ☐YES ☐NO
5. Has the person to be vaccinated ever felt dizzy or faint before, during, or after a vaccine? ☐YES ☐NO
6. Is the person to be vaccinated anxious about getting a vaccine today? ☐YES ☐NO

COVID-19 Vaccine Screening Questions

1. How old is the person to be vaccinated? ☐YES ☐NO
2. Is the person to be vaccinated sick today? ☐YES ☐NO
3. Has the person to be vaccinated ever received a dose of COVID-19 vaccine? ☐YES ☐NO
4. Does the recipient have a health condition or undergoing treatment that makes them moderately/severely immunocompromised? ☐YES ☐NO
5. Has the person to be vaccinated received a hematopoietic cell transplant (HCT) or CAR-T-therapy since receiving the COVID-19 vaccine? ☐YES ☐NO
6. Has the person to be vaccinated ever had an allergic reaction to a previous dose of COVID vaccine or a component of any COVID-19 vaccine? ☐YES ☐NO
7. Has the person to be vaccinated ever had anaphylaxis after another vaccine (other than COVID-19 vaccine) or another injectable medication? ☐YES ☐NO
8. Check all that apply for the person to be vaccinated:

☐ History of myocarditis or pericarditis
☐ History of Guillain Barre Syndrome (GBS)
☐ History of prior COVID-19 disease in the last 3 months
☐ History of thrombosis with thrombocytopenia syndrome (TTS)
☐ History of multisystem inflammatory syndrome (MIS-C or MIS-A)
☐ Been vaccinated with mpox vaccine in the last 4 weeks
☐History of immune-mediated syndrome characterized by thrombosis (HIT)

I do hereby state that I am the patient or parent/legal guardian of the patient listed above in SECTION 1. By signing below, I acknowledge that I consent to allowing Hancock Public Health healthcare providers to administer the selected vaccines to the patient listed above in SECTION 1. By signing below, I acknowledge that the *Notice of Privacy Practices* and *Consent for Services & Financial Responsibility* has been made available to me (linked on page 2), that I have read and understand it and that I have had the opportunity to ask questions and voice my concerns.

Patient or Parent/Legal Guardian Signature: _____ **Date:** _____ **Relationship to Patient:** _____

QR Codes to Consent Forms and Vaccine Information Statements

Consent for Service and Financial Responsibility and Notice of Privacy Practices

Influenza Vaccine

Pfizer COVID-19 Vaccine

Office Use Only

Influenza Vaccine

Date:	
Dose:	0.5 ml
Dose #:	1
Lot #: (Sticker)	
Route:	IM
Location:	LD RD LVL RVL
Given By:	

COVID-19 Vaccine

Date:	
Dose:	0.5 ml
Dose #:	1
Lot #: (Sticker)	
Route:	IM
Location:	LD RD LVL RVL
Given By:	