GEORGIA DEPARTMENT OF PUBLIC HEALTH
West Central Health District

Registration and Consent Form
Outreach Immunization Clinics

For Office Use Only
Patient #

SECTION I DEMOGRAPHIC INFORMATION

DATE	**IDENTIFICATION** *(Check One)* Driver's License ☐ Work ID ☐ Military ID ☐ Other _____		
PATIENT'S NAME (Last) (First) (Middle)			
PATIENT'S DATE OF BIRTH	**Age**	**PHONE NUMBER** ( )	**GENDER** *(Please Circle One)* MALE FEMALE
PATIENT'S ETHNICITY *(Please Circle One)* Not Hispanic/Latino Hispanic /Latino	**PATIENT'S RACE** *(Please Check ALL That Apply)* Black/African American ☐ White ☐ American Indian ☐ Asian ☐ American Indian ☐ Alaska Native ☐ Hawaiian/Polynesian ☐ Multicultural ☐ Other:_____		
PATIENT'S HOME ADDRESS (No PO Box please)			
CITY	**STATE**	**ZIP CODE**	**COUNTY**
TOBACCO USE *(Please Check Response):* YES☐ NO☐ If yes: smoke, smokeless, other_____	**IS THE PATIENT** *(Please circle one)* Single Married Separated Divorced Widowed		
PARENT OR GUARDIAN (if applicable) (Last) (First) (Middle)			
PATIENT'S PHYSICIAN	**YOUR RELATIONSHIP TO THE PATIENT:**		
YOUR NAME, IF NOT PARENT OR GUARDIAN (if applicable (Last) (First) (Middle)			

SECTION II PAYMENT TYPE

SOURCE OF PAYMENT *(Please Check One)* Cash ☐ VISA ☐ MasterCard ☐ Discover ☐	**DOES PATIENT'S INSURACE COVER IMMUNIZATIONS?** YES ☐ NO ☐

MEDICAL INSURANCE INFORMATION

NAME OF SUBSCRIBER_____ **DOB**_____**GROUP**_____ **MEMBER ID #**_____

_____ **NAME OF INSURANCE**_____

RELATIONSHIP TO PATIENT

DOES THE PATIENT HAVE A SECONDARY INSURANCE: YES ☐ NO ☐

NAME OF SUBSCRIBER_____ **DOB**_____**GROUP**_____ **MEMBER ID #**_____

_____ **NAME OF INSURANCE** _____

RELATIONSHIP TO PATIENT

SECTION III CONSENT AND HIPAA PRIVACY ACKNOWLEDGEMENT

I have been given a copy of the current Vaccine Information Statements for the vaccines requested today. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) to be given. I understand that participation and receipt of vaccinations through this program is completely voluntary. By signing below, I acknowledge I have been offered/given the privacy notice and I authorize permission for the vaccine(s) requested below to be administered.

DATE	PATIENT OR PARENT/GUARDIAN SIGNATURE	NURSE'S SIGNATURE

Patient's Name_____ **DOB** _____

The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't Know
1. Are you sick today?	☐	☐	☐
2. Do you have allergies to medications, food, or any vaccine?	☐	☐	☐
3. Have you ever had a serious reaction after receiving a vaccination	☐	☐	☐
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., disease), anemia, or other blood disorder?	☐	☐	☐
5. Do you have cancer, leukemia, AIDS, or any other immune system problem?	☐	☐	☐
6. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?	☐	☐	☐
7. Have you had a seizure, brain, or other nervous system problem?	☐	☐	☐
8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
Last Menstrual Period _____			
I am not now pregnant, and I accept the responsibility of not becoming pregnant for the next four weeks. (Initial) _____			
10. Have you received any vaccinations in the past 4 weeks?	☐	☐	☐

Form completed by:_____ Date: _____

Form reviewed by:_____ Date: _____

Copies of the Vaccine Information Statement for the Influenza vaccine will be provided at time of vaccination for your review

For Clinic Use Only Documentation of Vaccination Administration

1. Vaccine Administered:			**VIS Date:**	
Dose: ___cc	**Site: LEFT / RIGHT**	**Mfg. Lot No.**	**Expiration Date**	**Nurse's Signature**
2. Vaccine Administered:			**VIS Date:**	
Dose: ___cc	**Site: LEFT / RIGHT**	**Mfg. Lot No.**	**Expiration Date**	**Nurse's Signature**
3. Vaccine Administered:			**VIS Date:**	
Dose: ___cc	**Site: LEFT / RIGHT**	**Mfg. Lot No.**	**Expiration Date**	**Nurse's Signature**

Additional Nurse's Comments:

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