Georgia Department of Public Health
Coastal Health District

VACCINE INFORMATION AND CONSENT FORM

Name: _____ _____ _____
First Middle Last

Address: _____ _____ _____ _____
Street City State Zip

Telephone: (_____) _____--_____ _____
SSN

Date of Birth: _____--_____--_____	Age:	**Gender:** ☐Male ☐ Female	**Primary Language:** ☐ English ☐Other _____	**Ethnicity: (check only 1)** ☐ Not Hispanic ☐ Hispanic ☐ Unknown

Race: (check only 1) ☐Asian/Polynesian ☐Black ☐Multiracial ☐White ☐Native Am/Alaskan ☐Unknown

Please answer the health questions below:	**Yes**	**No**	**Don't Know**
1. Are you sick today?			
2. Are you allergic to anything including any food, any vaccine, any vaccine component, or latex?			
3. Have you ever had a serious reaction after receiving a vaccination?			
4. Have you received any vaccinations in the past four weeks?			
5. Do you, anyone you live with or take care of have a weakened immune system?			
6. Do you have any history of seizures or neurological conditions?			
7. Do you, anyone you live with or take care of take steroids, anti-cancer drugs or x-ray treatments?			
8. Is it possible that you are or may become pregnant in the next four weeks?			
9. In the last year have you received blood or plasma or been given immune globulin?			

Insurance/Payment Information (check only one)	
☐ Self-pay – Amount $	☐ Employer pays – Company Name:
☐ Medicaid #	☐ Medicare # Other:
☐Ambetter ☐BlueCross/BlueShield ☐Cigna ☐United Health ☐Aetna ☐Coventry ☐Humana ☐TRICARE Standard **Only**	
Insurance Group # or name:	Insurance Policy #:
Please include your insurance card to be copied and attached to this form.	

I have been given a copy and have read, or have had explained to me, the information in the Vaccine Information Statements for the vaccines indicated. I have had the chance to ask questions that were answered to my satisfaction. I believe that I understand the benefits and risks of the vaccines requested and ask that the vaccines indicated be given to me or the person named for whom I am authorized to make this request.

For Medicare Beneficiaries with Part B: I authorize the release of any medical or other information necessary to process this claim. I request payment of government benefits either to myself or the party who accepts assignment. I authorize payment of medical benefits to the undersigned physician or supplier for services described.

It is suggested that anyone getting a vaccine stay for 20 minutes after getting vaccinated before leaving.

_____ _____ **X**_____
Date **Print Name** **Patient/Guardian Signature**

OFFICE USE ONLY		**Record of Immunization**					**OFFICE USE ONLY**	
Vacc	**Manf**	**Lot #**	**Exp**	**Dsg**	**Rte**	**Ste**	**VIS**	**Nurse**

Date of Vaccination: _____

Revised August 2018