FCCHD CONSENT Ages 19 years and older

Patient Name: _____Date of Birth: _____/_____/_____Male / Female

Mailing Address: _____City:_____State:_____ZIP:_____

S.S.#_____ Home Phone: _____ Cell Phone: _____

Email Address: _____

Circle all that apply:					
Race:	**Hispanic:**	**Marital Status:**	**Student:**	**Employed:**	**Preferred Contact Method:**
White	Yes	Single	Full-Time	Full-Time	Mail
Black/Afr Amer	No	Married	Part-Time	Part-Time	Text/SMS
Asian		Divorced	No	Self-Employed	Email
Native HI/Other PI		Widowed		Retired	Phone
Amer Ind/AK Native		Separated		Unemployed	
Other		Partner			

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1	Is the person sick today?	Yes	No	Not sure
	If yes, what symptoms do they have?			
2	Is the person allergic to any food, medicine, preservative or latex?	Yes	No	Not sure
	If yes, list allergies:			
3	Has the person had any adverse reactions to previous vaccines?	Yes	No	Not sure
	If yes, list vaccines:			
4	Does the person have a medical condition such as Lung Disease (eg: Asthma), HIV/AIDS, Cancer, Heart Disease, Kidney Disease, Metabolic Disease (eg: Diabetes), brain/nervous system disorder (eg: seizures) or a blood disorder?	Yes	No	Not sure
	Does anyone else in the household?	Yes	No	Not sure
5	Is the person taking medications or treatments such as cortisone, steroid type drugs, chemotherapy, radiation therapy, organ anti-rejection drugs or long-term aspirin therapy?	Yes	No	Not sure
	Does anyone else in the household?	Yes	No	Not sure
7	Has the person received any blood products in the past year, including immune globulin?	Yes	No	Not sure
8	Is the person pregnant?	Yes	No	Not sure
9	Has the person received any vaccinations in the past 30 days?	Yes	No	Not sure

TB TEST ONLY: Have you been tested previously for TB? ___No ___Yes Result: _____ Unknown: _____

Reason for TB skin testing today:	**Have you experienced any of the following: Please check any that apply:**	
☐ Required by Employer	☐ Coughing up sputum or blood	☐ Unexplained Weight Loss
☐ School Entry Requirement	☐ Fatigue/Tiredness	☐ Night sweats
☐ Possible exposure to TB	☐ Loss of appetite	☐ Prolonged coughing (longer than 3 weeks)
☐ Experiencing Symptoms	☐ Fever or chills	
☐ Other:		

I have read or have had explained to me the information about the vaccine(s) being administered. I have received the Vaccine Information Statement (VIS) for each of the vaccines indicated. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and ask that the vaccine(s) be given to me or to the person named for whom I am authorized to make this request. I have had an opportunity to review the Flathead City-County Health Department Notice of Privacy Practices and receive an individual copy upon request. I have also been informed and understand that confidential health care information concerning me or the person for whom I am legally responsible, which may be provided to the Health Department or recorded in the course of receiving immunization services, is electronically recorded and retained in the Montana Public Health Data System. I understand that if my insurance is billed I am responsible to pay the co-payment, deductible payments and all charges for services not covered by my insurance plan.

X			
Signature of person to receive vaccine(s) or person authorized to make the request.	Initials	Relationship to person receiving vaccine	DATE