HAMPSHIRE COUNTY HEALTH DEPARTMENT

2023-2024 ADULT (19YRS-64YRS) INFLUENZA IMMUNIZATION REGISTRATION/CONSENT FORM

Patient Information		
Last Name:	First Name:	Middle Initial:
Mailing Address:		
City:	State:	Zip Code:
Home Phone:	Cell Phone:	
Date of Birth:	Sex: Male ☐ Female ☐	Marital Status: S M D W
Social Security Number:		
Primary Care Physician:		

Emergency Contact		
Last Name:	First Name:	Middle Initial:
Relationship to Patient:	Phone:	

Screening Questions for Adult Immunization	Yes	No	Unsure
Do you have any symptoms of illness today?			
Do you have any allergies to eggs, any components of the flu vaccine, latex, medications, food, or any other vaccine?			
Have you ever had Guillain-Barre Syndrome (GBS)?			
Have you ever had a serious reaction after receiving a vaccination?			
Have you ever felt dizzy or faint before, during, or after a shot?			
Do you have a long-term health problem with heart, lung, kidney, or metabolic disease (e.g. diabetes), asthma, or a blood disorder?			
Have you had a seizure, brain, or other nervous system problems?			
Do you have cancer, leukemia, AIDS, or any other immune system problem?			
Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?			
During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?			
For women: Are you pregnant or is there a chance you could become pregnant during the next month?			
Have you received any vaccinations in the past 4 weeks?			

The HCHD Notice of Privacy Practices provides information about how we may use and disclose your protected information. The Notice of Privacy Practices is subject to change. A copy of our notice is available upon request. By signing this form, you acknowledge that they HCHD Notice of Privacy Practices was made available to you.

I have read or had explained to me the Vaccine Information Statement for the vaccine I am to receive, and I understand the risk and benefits. Vaccine Information Statements (VIS Forms) have been made available to me and I understand the information about the vaccine(s).

Hampshire County Health Department can bill the insurance listed for the immunizations. I request that payment of authorized third-party benefits be made to Hampshire County Health Department for services furnished by the department. ***Submission of insurance information does not guarantee coverage. I understand that if the insurance company does not cover the vaccine(s), I will be responsible for payment.***

Patient Signature: ____ **Date:**________________

Witness/Title: ____ **Date:**________________

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Hampshire County Health Department Use

Primary Medical Insurance		
Insurance Company Name:		
Insurance Company Address:		
City:	State:	Zip Code:
Insurance Company Phone Number:		
Policy Holder Name:		
Policy Holder Date of Birth:	Relationship:	
Policy Identification Number:		
Group Number:		

Influenza

Lot # ________________
R deltoid L deltoid
Nurse Initial:_______________

Tdap____ Td____

Lot # ______________
R deltoid L deltoid
Nurse Initial:_______________

Shingrix
Dose 1: ____ Dose 2: ____
_____ Private _____ State Supplied

Lot # ______________
R deltoid L deltoid
Nurse Initial:_______________

Hepatitis A – Adult

Lot # ______________
R deltoid L deltoid
Nurse Initial:_______________

PCV13 ____ PCV15 ____ PCV20____

Lot # ______________
R deltoid L deltoid
Nurse Initial:_______________

Pneumovax 23 ____

Lot # ______________
R deltoid L deltoid
Nurse Initial:_______________

RSV - Abrysvo

Lot # ______________
R deltoid L deltoid
Nurse Initial:_______________

Hepatitis B – Adult

Lot # ______________
R deltoid L deltoid
Nurse Initial:_______________

Hampshire County Health Department
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Bryan M. Steward, MD
NPI: 1801231295

Location:______________________________

Patient Payment Amount: ________________
Cash:____ **Check:**____ **Check #:**_______

Entered: WVSIIS _______
PracticeMate _______