Health Center KNOX COUNTY COMMUNITY MOUNT VERNON DANVILLE
Healthcare For Everyone
740-399-8008

Knox PUBLIC HEALTH

Vaccine Consent Form

Patient Information (Please Print)			
First Name: **MI:** **Last Name:**		**Date of Birth** **Age:**	**Phone #:**
Mailing Address:			**SS# or DL#**
City:	**State:**	**Zip:**	**County:**
Gender:	**Race:**	**Ethnicity:** Hispanic/Latino ☐	Not Hispanic/Latino ☐

Do you live within Mount Vernon city limits? ☐ **Yes** ☐ **No**

Complete if the patient is 18 years of age or younger, attending school, or has a legal guardian: For all minor patients (18 years of age or younger), legal guardians will be asked to show documentation to prove that a legal relationship exists. This is for both the safety of the child and guardian and to ensure that the legally appointed parent or guardian is responsible for making medical decisions on behalf of the minor. Applicable legal documents pertaining to custody, divorce, separation, adoption, or name change of parent of child are required.

Current Custody Status: ☐ Parent ☐ Sole Parental Custody ☐ Joint Legal Custody ☐ DSS Custody ☐ Other _____

Parent/Guardian Name: _____ Relationship to Patient: _____
Home Phone: _____ Cell Phone: _____
Mailing Address (if different than patient): _____

Insurance Information ☐ (check here if you do not have health insurance)

Policy Holder's Name (parent/spouse/guardian):

Policy Holder's Birthdate (parent/spouse/guardian):

I have private health insurance ☐	**I have Medicare ☐**	**I have Medicaid ☐**
Name of Primary Plan:	Name of Primary Plan:	Name of Primary Plan
Member ID#	Member ID#	Member ID#
Group #	Group #	Group #
Name of Secondary Plan	Name of Secondary Plan	Name of Secondary Plan
Member ID#	Member ID#	Member ID#
Group #	Group #	Group #

The Knox Public Health or Health Center may keep this record in your medical file. They will record what vaccine was given, date the vaccine was given, the name of the company that made the vaccine, the vaccine special lot number, the signature and title of the person who gave the vaccine, and the address where the vaccine was given. I understand as a condition of receiving care with KCCHC, my personally identified health information may be disclosed for treatment, payment, and health care operation purposes. I understand that this information will be released to a state-wide Immunization Registry for the purpose of immunization tracking recall and recording. I have read or have had explained to me the Vaccine Information Sheet regarding the vaccine(s) being received today. I have had a chance to ask questions, and they 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 the person named above for whom I am authorized to make this request. A copy of the Notice of Privacy Practices (HIPAA) will be provided upon request, and it is also located on our website at www.knoxhealth.com.

Patient/Guardian Signature: _____ Date: _____

Relationship to Patient: _____

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Patient Name _____ Date of Birth _____

Vaccine Screening Questions	
1. Are you currently pregnant or breast feeding?	☐ YES ☐ NO
2. Are you sick today?	☐ YES ☐ NO
3. Have you ever had a serious (anaphylactic) reaction after receiving a vaccination?	☐ YES ☐ NO
4. Do you have a weakened immune system?	☐ YES ☐ NO
5. Have you recently received a blood transfusion or received other blood products?	☐ YES ☐ NO
6. Have you received any other vaccines in the last four weeks?	☐ YES ☐ NO
7. Have you received a flu and/or covid vaccine in the past?	☐ Flu ☐ Covid
8. Children under 9: Have you received two flu vaccines in the past?	☐ YES ☐ NO
9. Have you ever had a paralyzing illness after receiving a flu vaccine? (Guillain Barre)	☐ YES ☐ NO
10. Please list all allergies here: _____	

FOR OFFICE USE ONLY

(Back to School Vaccines) **(Vaccine Source: VFC___ 317___ Private ___)**

MMR MMRII ___ Priorix ___ **Lot /Expiration** _____ **Injection Site:** _____	**Tdap/Dtap** Boostrix/Adacel (Tdap) ___ Infanrix/Daptacel (Dtap) ___ **Lot /Expiration** _____ **Injection Site:** _____	**Meningitis ACWY** Menveo ___ MenQuadFi ___ **Lot /Expiration** _____ **Injection Site:** _____
Varicella (Varivax) **Lot /Expiration** _____ **Injection Site:** _____	**Dtap+Polio** Kinrix ___ Quadracel ___ **Lot /Expiration** _____ **Injection Site:** _____	**Hepatitis B** Engerix B ___ Recombivax HB ___ **Lot /Expiration** _____ **Injection Site:** _____
MMRV (Proquad) **Lot /Expiration** _____ **Injection Site:** _____	**Polio** (Ipol) **Lot /Expiration** _____ **Injection Site:** _____	**Other:** _____ **Lot /Expiration** _____ **Injection Site:** _____
Dtap+Polio+Hepatitis B (Pediarix) **Lot /Expiration** _____ **Injection Site:** _____	**Hib** Hiberix ___ Act Hib ____ **Lot /Expiration** _____ **Injection Site:** _____	**Rotovirus** Rotarix ___ RotaTeq ___ **Lot /Expiration** _____ **Injection Site:** _____
Pneumonia Prevnar 20 ___ Pneumovax 23 ___ **Lot /Expiration** _____ **Injection Site:** _____	**Hepatitis A** Havrix ___ Vaqta ___ **Lot /Expiration** _____ **Injection Site:** _____	**Meningitis B** Bexsaro ___ Trumenba ___ **Lot /Expiration** _____ **Injection Site:** _____
HPV (Gardasil) **Lot /Expiration** _____ **Injection Site:** _____	**Influenza** Regular___ High Dose ___ **Lot /Expiration** _____ **Injection Site:** _____	**Shingles** (Shingrix) **Lot /Expiration** _____ **Injection Site:** _____
COVID 19 Pfizer ___ Moderna___ **Lot /Expiration** _____ **Injection Site:** _____	**RSV** Beyfortus 50mg/Beyfortus 100mg ___ Abrysvo ___ **Lot /**Expiration _____ **Injection Site:** _____	**Other** _____ **Lot /Expiration** _____ **Injection Site:** _____

Name of vaccinator _____**Signature** _____ **Date** _____

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