RED WILLOW COUNTY
HEALTH DEPARTMENT

ADULT VACCINE ASSESSMENT FORM
INSURED

PERSONAL INFORMATION

Legal Name : _____

Date Of Birth : _____ / _____ / _____ **Age:** _____ **Gender :** ☐ Male ☐ Female

Address : _____ **City :** _____ **State:** _____ **Zip:** _____

Phone Number : _____ **Mother's First & Maiden Name :** _____

***Primary Insured's Name & Date of Birth :** _____

Would you like online access to your immunization records? ☐ Yes ☐ No

ASSESSMENT QUESTIONS

These questions help determine the vaccines you may be given today. A "yes" answer does not mean you should not be vaccinated, it just means additional questions must be asked. If a question is not clear, please ask one of the nurses to explain it.

1. Are you sick today?	☐ YES	☐ NO
2. Do you have allergies to medications, gelatin, neomycin, food, eggs, yeast, a vaccine component or latex?	☐ YES	☐ NO
3. Have you ever had a serious reaction after receiving a vaccination?	☐ YES	☐ NO
4. Do you have any of the following: long-term health problems with heart, lung, kidney, metabolic disease (i.e. diabetes), asthma, a blood disorder, no spleen, a cochlear implant or spinal fluid leak? Are you on long term aspirin therapy?	☐ YES	☐ NO
5. Do you have cancer, leukemia, HIV/AIDS, or any immune system problem?	☐ YES	☐ NO
6. Do you have a parent, brother, or sister with an immune system problem?	☐ YES	☐ NO
7. In the past 6 months, have you taken medications that affect your immune system, such as cortisone, prednisone or other steroids; anticancer drugs, drugs for treatment of rheumatoid arthritis, Crohn's disease or psoriasis; or have you had any radiation treatments?	☐ YES	☐ NO
8. Have you ever had a seizure, brain, or other nervous system problem; or Guillain-Barre' Syndrome?	☐ YES	☐ NO

***Please turn page over.**

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9. Have you ever been diagnosed with a heart condition (myocarditis or pericarditis) or have you had Multisystem Inflammatory Syndrome (MIS-A or MIS-C) after an infection with the virus that causes COVID-19?	☐ YES	☐ NO
10. In the past year, have you received immune (gamma) globulin, blood/blood products, or an antiviral drug?	☐ YES	☐ NO
11. For women: Are you pregnant or is there a chance you could become pregnant in the next month? (or) Do you have a mammogram scheduled in the next 6 weeks?	☐ YES	☐ NO
12. Have your received any vaccinations in the past 4 weeks?	☐ YES	☐ NO
13. Have you ever felt dizzy or faint before, during or after a shot?	☐ YES	☐ NO
14. Are you anxious about getting a shot today?	☐ YES	☐ NO

PRIVACY ACT, PATIENT CONSENT, & BILLING AUTHORIZATION

ACKNOWLEDGEMENT OF AWARENESS OF PRIVACY ACT: By my signature below, I acknowledge that I am aware of Red Willow County's privacy rules and upon request can obtain a copy of the Notice of Privacy Act of Red Willow County Health Department, 1400 West 5th, McCook, NE 69001. I understand this notice describes how my health information will be used and/or disclosed by the facility. **PATIENT CONSENT:** I have read the current Vaccine Information Sheet or have had the VIS information explained to me. I have had a chance to ask questions, and these have been answered to my satisfaction. I understand the benefits and risks of the vaccine and ask that the vaccine be given to me, or to the person named above (for whom I am authorized to make this request). I accept responsibility for seeking medical attention for any problems I may have with this vaccination. ***I AUTHORIZE BILLING OF ALL VACCINATIONS TO MY HEALTH INSURANCE. ***I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THOSE CHARGES NOT PAID BY MY INSURANCE COMPANY.**

Signature : _____ Date : _____

OFFICE USE ONLY

Medicare/Insurance Card : _____ **TR-ACT E/PD:** _____

Bill To : _____ **PT. PD CK/CASH:** _____

NESIIS: ☐ **INS. FILED:** _____ **INS. PMT $:** _____

Screening questions reviewed and OK: _____

Date Administered : _____ **Body Site :** _____