GALLIA COUNTY GENERAL HEALTH DISTRICT
499 Jackson Pike, Suite D, Gallipolis, OH 45631
Gerald E. Vallee, M.D., Health Commissioner

ADULT IMMUNIZATION CONSENT FORM

Name: (Last)_____(First)_____(MI)_____

Birthdate: _____Age:_____ Race:_____Telephone: _____S.S.#_____

Address: _____ (City)_____(State)_____(Zip)_____

_____ Private Insurance _____Medicare
_____ Insurance does not cover vaccine's
_____ No insurance
_____Medicaid _____ United Healthcare Community Plan _____ Molina _____ Caresource

PLEASE ANSWER THE FOLLOWING QUESTIONS

	Yes	No	Explain
1. Are you sick today?	☐	☐	_____
2. Do you have allergies to medications, food, or any other vaccine?	☐	☐	_____
3. Have you ever had a serious reaction after receiving a vaccine?	☐	☐	_____
4. Do you have cancer, leukemia, AIDS, or any other immune system problem?	☐	☐	_____
5. Do you take cortisone, prednisone, other steroids, anticancer drugs, or have you had x-ray treatments?	☐	☐	_____
6. During the past year, have you received a transfusion of blood, or blood products, or been given a medicine called immune (gamma) globulin?	☐	☐	_____
7. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	_____
8. Have you received any vaccinations in the past 4 weeks?	☐	☐	_____
9. Do you have a blood clotting disorder such as hemophilia or thrombocytopenia, or take anticoagulants (blood thinners)?	☐	☐	_____

I have read or have had explained to me the Vaccine Information Statement for the vaccines that I (or my child) am about to receive today. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccines and request that it be given to me or to the above named for whom I am authorized to make this request. I also authorize the release of immunization information to other health care agencies, schools, and place of employment at the discretion of the Health Department staff. I authorize the Health Department to bill for my (or my child's) service today. The presence of my signature certifies that I have received information on the HIPAA Privacy Notice.

_____ _____
Signature of Client / Authorized Guardian Date

Gallia County Health Department operates in accordance with Title VI of the Civil Rights Act of 1964

PLEASE COMPLETE SIDE TWO IF REQUESTING A TETANUS DIPHTHERIA (Td).

SIDE 2

REQUEST FOR TETANUS DIPHTHERIA (Td)

I, _____ request that the Nursing Staff of the Gallia County Health Department administer the ADULT TETANUS DIPHTHERIA (Td) booster to me. I need the Td vaccine because (of an injury or for routine vaccine). The nursing staff has informed me and I
circle one
understand that this vaccine will not prevent or treat any bacterial infection I may contract from an injury. Further, they have recommended that I seek medical attention for actual wound treatment.

PERSONS WHO ARE SENSITIVE TO THIMEROSAL SHOULD NOT TAKE THE TETANUS/DIPHTHERIA VACCINE

1. ☐ I have received the Tetanus vaccination series in the past.

2. ☐ The date of my last booster was _____.

3. ☐ I am unsure of the exact date, but believe it has been longer than 10 years since my last Td shot. I have read the Td vaccine information statement and an aware that if given too often, a hypersensitivity to the vaccine could develop. I understand this could result in a massive local reaction at the vaccination site (painful swelling from shoulder to elbow).

   I understand that the nurses and the Gallia County Health Department are not liable for any side effects I may experience from the vaccine. These possible side effects have been explained to me, and I voluntarily request that this vaccine be administered to me.

_____ _____
Signature of Client / Authorized Guardian Date

_____ _____
Witness Date