## ADULT VACCINE PROGRAM

A	DULI VACCINE PI						
	PATIENT INFORMAT	ION					
NAME:	LAST	BIRTHDATE:	_ SE	EX: M	F		
ADDRESS							
	CITY	STATE		ZIP C	ODE		
COUNTY:	EMAIL:						
HOME PHONE:	CELLPHONE:	BIRTH STATE:	BIRTH STATE:				
ALLERGIES:	LANGUAGE:	PHYSICIAN:					
RACE: O MULTI-RACIAL O AMERICAN INDIAN O ASIAN O NAT.HAWAIIAN, PAC ISL	O WHITE O AFRICAN A O OTHER	MERICAN					
ETHNICITY: O HISPANIC O NON-HISPANIC O U	JNKNOWN						
ADULT VACCINE	e program - patient elig	IBILITY SCREENING RECORD					
<ul> <li>TO BE ELIGIBLE TO RECEIVE PUBLICLY FUNDED VACCINES</li> <li>1. UNINSURED – NO PRIVATE HEALTH INSURANCE COVI</li> <li>2. UNDERINSURED – PRIVATE HEALTH INSURANCE THAT (INTERNATIONAL TRAVELERS DO NOT MEET THE ELIC</li> </ul>	YERAGE IT DOES NOT PROVIDE COVERAGE	FOR A SPECIFIC VACCINE OR ALL ACIP RECOMMENED					
(CHECK ONLY ONE BOX): THE PATIENT DOES NOT HAVE INSURANCE. THE PATIENT IS UNDERINSURED (HAS HEALTH IN THE PATIENT HAS HEALTH INSURANCE THAT PRESENT I HEREBY RELEASE THE DEARBORN COUNTY HEALTH DEPARTMENT, ITS AC CHILD/CHILDREN/OR MYSELF INCULDING, BUT NOT LIMITED TO, LOCAL INFORMATION IN THE "VACCINE INFORMATIONS STATEMENT" FOR THE LISS SATISFACTIONS. I BELIEVE THAT I UNDERSTAND THE BENFITS AND RISKS MEDICAL CARE PROVIDERS, IF REQUESTED, TO AVOID THE ADMINISTRATION	COVIDES COVERAGE FOR VACCI GENTS AND EMPLOYEES, FROM ALL LIA INFLAMMATION AND ALLERGIC REACT. DISEASE(S) AND VACCINE(S) RECEIVED T OF THE VACCINE REQUESTED. I AGREE	NES (INELIGIBLE FOR PUBLICLY FUNDED VACCI BILITY RESULTING FROM VACCINATION AND IMMUNIZATION ONS. I HAVE BEEN GIVEN A COPY OF, AND HAVE READ OF F ODAY. I HAVE HAD CHANCE TO ASK QUESTIONS THAT WERN TO ALLOW INFORMATION ABOUT ANY VACCINATIONS GIVE	NS GIVEN HAD EXPLA E ANSWER	INED TO ED TO M	IY		
SIGNATURE - PARENT OR LEGAL GUARDIAN	PRINT NAME	- PARENT OR LEGAL GUARDIAN	DATE				
	ST FOR CONTRAINDICAT	IONS TO VACCINES FOR ADULTS					
FOR PATIENTS: The following questions will help us deterr			oes not r	iecessai	rily mean		
you should not be vaccinated. It just means additional question	ns must be asked. If a question is r	oot clear, please ask your healthcare provider to exp	ain it.				
			YES	NO	UNSURE		
1. ARE YOU SICK TODAY?							
2. DO YOU HAVE ALLERGIES TO MEDICATIONS, FO	OOD, A VACCINE COMPONE	NT, OR LATEX?					
3. HAVE YOU HAD A SERIOUS REACTION AFTER R	RECEIVING A VACCINATION?						
4. DO YOU HAVE A HEALTH PROBLEM WITH LUNG ASTHMA, OR A BLOOD DISORDER?	G, HEART, KIDNEY OR META	BOLIC DISEASE (E.G., DIABETES),					
5. DO YOU HAVE CANCER, LEUKEMIA, HIV/AIDS, O	OR ANY OTHER IMMUNE SY	STEM PROBLEM?					

6.	IN THE PAST 3 MONTHS, HAVE YOU TAKEN MEDICATIONS THAT WEAKEN YOUR IMMUNE SYSTEM SUCH AS
	CORTISONE, PREDNISONE, OTHER STEROIDS, OR ANTICANCER DRUGS, OR HAVE YOU HAD RADIATION
	TREATMENTS?

7. HAVE HAD A HAD A SEIZURE OR A BRAIN OR OTHER NERVOUS SYSTEM PROBLEMS?

8.	DURING THE PAST YEAR, HAVE YOU RECEIVED A TRANSFUSION OF BLOOD OR BLOOD PRODUCTS, OR BEEN GIVEN IMMUNE (GAMMA) GLOBULIN OR AN ANTIVIRAL DRUG?		
9.	FOR WOMEN: ARE YOU PREGNANT OR IS THERE A CHANCE YOU COULD BECOME PREGNANT DURING THE NEXT MONTH?		
10.	HAVE YOU RECEIVED VACCINATIONS IN THE PAST 4 WEEKS?		
11.	Do you use tobacco products? (Including: Vapes, E-cigarettes, Cigars, Cigarillo's, traditional cigarettes or chewing tobacco)		
12.	If you answered YES to question #11 – Would you like FREE help to quit?		

## ADMINISTERED VACCINES: (OFFICE USE ONLY)

VACCINE: SHINGRIX	DOSE:	LOT#/MFR:	SITE: IM	VIS 10/30/19	VACCINE: PCV-13	DOSE:	LOT #/MFR:	SITE IM	VIS 10/30/19
vaccine: Tdap	DOSE:	LOT#/MFR:	SITE: IM	VIS 4/1/20	VACCINE: MCV 4	DOSE:	LOT #/MFR:	SITE	VIS 8/15/19
VACCINE: HEP B	DOSE:	LOT#/MFR:	SITE: IM	VIS: 8/15/19	VACCINE: MEN B	DOSE:	LOT #/MFR:	SITE	VIS 8/15/19
VACCINE: IPV	DOSE:	LOT#/MFR:	SITE: IM/SQ	VIS 10/30/19	VACCINE: HPV 9	DOSE:	LOT #/MFR:	SITE	VIS 10/30/19
VACCINE: MMR	DOSE:	LOT#/MFR:	SITE: SQ	VIS 8/15/19	VACCINE: HEP A	DOSE:	LOT #/MFR:	SITE IM	VIS 7/28/20
VACCINE: HIB	DOSE:	LOT#/MFR:	SITE: IM	VIS 10/30/19	VACCINE: PPSV 23	DOSE:	LOT #/MFR:	SITE IM	VIS 10/30/19
VACCINE: VARICELLA	DOSE:	LOT#/MFR:	SITE: SQ	VIS 8/15/19	VACCINE: FLU	DOSE:	LOT #/MFR:	SITE	VIS: 8/15/19
VACCINE: RABIES	DOSE:	LOT#/MFR:	SITE: IM	VIS 01/08/20	VACCINE: TYPHOID	DOSE:	LOT #/MFR:	SITE	VIS 10/30/19

NURSE SIGNATURE

DATE