



Vaccination Screening/Consent Form

NORTH CENTRAL DISTRICT HEALTH DEPARTMENT
422 E. DOUGLAS STREET, O'NEILL, NE 68763
MON-FRI 8:00 AM - 4:30 PM 402-336-2406



LAST NAME FIRST NAME MIDDLE NAME MAIDEN NAME

AGE BIRTHDATE GENDER (FEMALE/MALE) MOTHER'S MAIDEN NAME (First & Last)*

STREET ADDRESS MAILING ADDRESS (IF DIFFERENT)

CITY STATE ZIP PHONE # () - *Used to Verify Recipient in NESIIS

1 Are you sick today? 2 Do you have allergies to medications, gelatin, yeast, eggs, latex or any vaccine? 3 Have you ever had a serious reaction to a vaccine in the past? 4 Have you ever had a seizure or a neurological problem? 5 Have you ever had Guillian-Barre syndrome? 6 For children 8 years and younger: Is this the first time he/she has received an Influenza vaccine?

INSURANCE QUESTIONS

Private Insurance-Vaccine Covered Heritage Health/Medicaid No Insurance
Private Insurance-Vaccines NOT covered American Indian/Alaska Native

If submitting to insurance, who is the primary policy holder? Name as it appears on the card:

Insurance

Policy/Member/ID #:

Fill out the shaded areas if the Recipient is NOT the policyholder.

Policyholder's Mailing Address Policyholder Gender: M F Policyholder's Birthdate:
Relationship to policyholder: Spouse Child Other
City State Zip Policyholder's phone #: () -

Please bring insurance card or a copy of the front and back of the insurance card with you.

I GIVE CONSENT to North Central District Health Department and its staff to vaccinate the person listed on this form. I have received and read or had explained to me the Vaccine Information Statement(s) or Emergency Use Authorization(s) and I understand the benefits and risks of the vaccine(s) and their presently known side effects. Furthermore, I understand that there is no guarantee of immunity or that the client will not experience an adverse reaction to the vaccine(s). In the event of adverse side effects or that immunity does not occur, I hereby hold NCDHD harmless for any and all liability to the extent permitted under the law. If the person named above is under 19 and is not accompanied by an adult, I agree to allow the school agent or NCDHD agent to act on my child's behalf. I also acknowledge that North Central District Health Department has made their Notice of Privacy available for review. I understand that I may request a copy of the Notice of Privacy. I hereby grant permission to North Central District Health Department to release any pertinent information to the insurance carrier listed upon request and any physicians to whom I might be referred. If not eligible for Vaccines for Children Program (VFC) or Adult Immunization Program (AIP), I understand that I am responsible for charges not paid by my insurance company. All vaccines administered by NCDHD will be entered into NESIIS (Nesbraska State Immunization Information System). I give consent for the vaccinations requested to be given to me (or the person named above for whom I am authorized to make this request and provide surrogate consent). I also give consent for the following: (check YES or NO)

1 I authorize NCDHD to release information from the client's medical record re: immunization status to the following entities: client family/guardians/representatives, child care, school or work-related authorities. YES NO
2 I authorize NCDHD to photograph me and/or my child(ren) during the services provided and utilize the image(s) for publishing and/or distribution. YES NO

Patient Signature: *if recipient is under 19, a parent or guardian must sign consent

Date:

If recipient is under 19 & not accompanied by an adult, this section must be filled out: Emergency Contact information

Emergency Contact Name (please print): Emergency Contact Phone #: () -

WE REQUEST THAT YOU STAY ON SITE FOR 15 MINUTES AFTER RECEIVING YOUR VACCINATION(S). IF YOU CHOOSE TO LEAVE, YOU ASSUME ALL RESPONSIBILITY/LIABILITY FOR ANY ADVERSE EVENT. THANK YOU.