



NEW MEXICO DEPARTMENT OF HEALTH ADULT VACCINE CONSENT FORM

This form is to be used for patients aged 19+ and older ONLY

Revised 02/2018

Last Name: _____		First Name: _____		Middle Initial: _____	
Birth Date: _____ <small>Month / Day / Year</small>		Mother's Maiden Name: _____ <small>First and Last Name</small>			
Mailing Address: _____			City: _____		State: <u> </u> NM Zip: _____
Daytime Phone: _____		Responsible Person: _____ <small>First and Last Name</small>		Relationship: _____	

Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Race: <input type="checkbox"/> American Indian/Native American/Alaskan Native <input type="checkbox"/> Black/African American	Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander	Other <input type="checkbox"/> White	Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
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INSURANCE INFORMATION – Fill the appropriate category – REQUIRED

Centennial Care/Medicaid: <input type="checkbox"/> Blue Cross Blue Shield		<input type="checkbox"/> Molina Healthcare	<input type="checkbox"/> Presbyterian	<input type="checkbox"/> United Healthcare
Policy/ Member ID # _____		Centennial Care Medicaid #: _____		Group #: _____
Medicare Part B: Subscriber ID # _____ Responsible Party: _____ Policy Holder's Date of Birth: _____				
<input type="checkbox"/> No Insurance		<input type="checkbox"/> Private Insurance		

MEDICAL SCREENING QUESTIONS - REQUIRED

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means that additional questions must be asked. If a question is not clear, please ask your health care provider to explain it.	No	Yes	Don't Know
1. Are you sick today?			
2. Do you have allergies to medications, food, a vaccine component, or latex? Such as: neomycin, eggs, gelatin, MSG? Please list: _____			
3. Have you ever had a serious reaction after receiving a vaccination?			
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (ex: diabetes), anemia or other blood disorder?			
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?			
6. In the past 3 months, have you taken medications that affect your immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease or psoriasis; or have you had radiation treatments?			
7. Have you had a seizure, brain, or other nervous system problem? Such as Guillain-Barre Syndrome 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 any vaccinations in the past 4 weeks?			

CONSENT FOR VACCINATION

I have been given and have read or have had explained to me, the information in the Vaccine Information Statement(s) for the diseases and vaccine(s) checked below. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine requested and ask that the vaccine checked below be given to me or the person named for whom I am authorized to make this request. I request that payment of authorized benefits be made to the New Mexico Department of Health/Public Health Division/Immunization Program, for services furnished to me by that program. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable for related services. I specifically authorize the release of my Medicare or other insurance policy number to the NM Department of Health to allow the Department of Health to seek reimbursement for the vaccine and administrative costs. Unless I sign a statement signifying otherwise, I allow immunization information to be entered into the New Mexico Statewide Immunization Information System (NMSIIS) and be released to other medical care providers to avoid unnecessary vaccination or to ascertain immunization status. The DOH Privacy Policies are available at <http://nmhealth.org/hipaa.shtml> and will be given to all patients when they receive an immunization.

Signature (Client/Guardian): _____ Date: _____

FOR CLINIC USE ONLY

Vaccine	Lot #	Exp. Date	Site & Route	Funding: 317 or State	Date of VIS
Vaccinator (print name):		Signature:		Date of Service:	
Title of Vaccinator:		VFC Pin#:		Date VIS Given:	
Date NMSIIS Entered:		Date TransactRx Entered:		Notes:	
Address/location of vaccines given:					