Adult Vaccination Clinic Consent Form

Porter County Health Department

Office Use Only SIIS#

PLEASE PRINT

Patient's Last Name	First Name	MI	Date of Birth MMDDYYYY	Age
			- -	

Listed under any alias or other name? If so; Last Name Used	First Name Used	Gender ✓	Physician's Name
		❒ Male ❒ Female	

Patient's Race ✓: ❒African American ❒ Caucasian ❒ American Indian/Eskimo ❒ Other ❒ Multiracial ❒ Hispanic	U.S. State or Foreign Country of Birth	What Language is spoken at home?

Current Street Address:	City	State	ZIP Code	Home/Primary Phone Number
				( ) -

**If insurance coverage is declined or rejected after submission it will be your responsibility to pay any outstanding amounts due us. We will process your claim through a third party service it is they who will determine final eligibility. There could be a delay as long as 60 plus days for final settlement.*

Primary Insurance Company Name:	
Member ID:	
Group Number:	
Policy Holder's Full Name:	
Policy Holder's Date of Birth:	--- ---

Screening: Please answer all questions. Answers determine which vaccines the person named above can receive today. ✓	YES	NO
1. Are you sick today? Please Explain:		
2. Do you have allergies to medications, food, or any vaccine? List:		
3. Have you had a serious reaction to a vaccine in the past?		
4 Do you have/ever had epilepsy, Guillain-Barre Syndrome, seizures or any brain disorder?		
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?		
6. Has your thymus been removed? Do you have a thymus disorder such as Myasthenia Gravis, or Di George Syndrome?		
7. Do you have a low platelet count or blood disorder?		
8. In the past 3 months have you taken cortisone, prednisone or other steroids for longer than 14 days? Have you taken any cancer fighting treatments (radiation/chemotherapy) in the past year?		
9. Have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin in the past year?		
10. Have you received vaccinations in the past 4 weeks? If yes, list:		
11. Have you ever fainted after receiving vaccines?		
12. Females only , - is there a chance you are pregnant or could become pregnant during the next month?		

**** I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ANY FEES INCURRED NOT COVERED BY MY INSURANCE. ****

Consent to Vaccinate:
By signing below you are stating that you had the opportunity to receive a copy of our HIPAA Compliance Policy. You also state that all information on this form is correct.

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Patient Signature	Date (mm/dd/yy)	Nurse's Signature	Date (mm/dd/yy)
Print Name			

Adult VACCINE ADMINISTRATION PATIENT RECORD

LAST NAME:	FIRST NAME:	MI	DATE OF BIRTH:

DO NOT WRITE BELOW THIS LINE-FOR CLINIC USE ONLY

CLINIC- PORTER COUNTY HEALTH DEPARTMENT:
❒ 155 INDIANA AVE., VALPARAISO, IN 46383
❒ 3590 WILLOWCREEK RD,, PORTAGE, IN 46368
❒ (other):

DATE VACCINATED AND
DATE VIS PROVIDED TO PARENT / GUARDIAN / PATIENT
Vaccine Charge:
❒ VaxCare ❒ Self- Pay ❒ 317 ❒ Other

VACCINE	DOSE	MANUFACTURER & LOT NO.	ROUTE / SITE	DATE OF VIS	CPT CODE
Tdap/Td 0.5ml			IM	01/31/2025	90715/90714
IPV 0.5ml			Sub q/IM	01/31/2025	90713
MMR 0.5 ml			Sub Q	01/31/2025	90707
Hep A 1.0 ml			IM	01/31/2025	90632
Hep B 1.0ml			IM	01/31/2025	90716
Twinrix (HepA& B) 1.0ml			IM	08/06/2021	90636
Varicella 0.5ml			Sub Q	01/31/2025	90716
Menquadfi ACWY 0.5ml			IM	01/31/2025	90619
Bexsero (MenB) 0.5ml			IM	01/31/2025	90620
PCV 20 0.5ml			IM	05/12/2023	90677
Influenza 0.5ml TYPE:			IM	01/31/2025	90686
HPV 9 0.5ml			IM	08/06/2021	90651
Shingrix 0.5ml			IM	02/04/2022	90750
RSV 0.5ml			IM	07/24/2023	90381
Spikevax(Moderna) 0.5ml			IM	01/31/2025	91318
Typhoid 0.5ml			IM	10/30/2019	90691
Yellow Fever 0.5ml			Sub Q	04/01/2020	90717
Rabies 1.0 ml			IM	06/02/2022	90675
Japanese Enc 0.5ml			IM	08/15/2019	90738
Cholera			oral	01/31/2025	90625

Nurse's Authorization		Office Use Only: Input Responsibilities			
Date	Nurse's Signature	CHIRP Date	CHIRP Initials	UPP Date	UPP Initials