

NEW MEXICO DEPARTMENT OF HEALTH ADULT VACCINE CONSENT FORM

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

Revised 01/2019

Last Name:	First Name:				Middle Initial:			
Birth Date: Mother's Maiden Name: First and Last Name								
Mailing Address:					e:NM Zi ŗ	NM Zip :		
Daytime Phone:								
Gender: ☐ Male Race: ☐ An	nerican Indian/Native Am		Last Name Asian	Other	Ethnicity:	lispanic		
	nck/African American	Native Hawaiian,		White		lon-Hispan	iic	
INSURANCE INFORMATION – Fill the appropriate category – REQUIRED								
Centennial Care/Medicaid: Blue Cross Blue Shield Presbyterian Western Sky								
Policy/ Member ID # Centennial Care Medicaid #:						Group #:		
Medicare Part B:								
Subscriber ID # Policy Holder's Date of Birth:								
No Insurance								
MEDICAL SCREEING QUESTIONS - REQUIRED For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any								
						V	Don't	
question, it does not necessarily mean question is not clear, please ask your h			iat additional questi	ons must be asked.	If a No	Yes	Know	
Are you sick today?	eaitii care provider to e	xpiaiii it.						
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 Medicard Services and its agents any information peeded to determine these benefits payable for related services. I specifically authorize the release of my Medicare or other								
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 US	E ONLY					
Vaccine	Lot #	Exp. Date	Site & Rout	te Fundin	g: 317 or State	Date	e of VIS	
Vaccinator (print name):		Signature:		Date of	Date of Service:			
Title of Vaccinator:		VFC Pin#:			Date VIS Given:			
Date NMSIIS Entered:	Date TransactRx Enter	Notes:	Notes:					
Address/location of vaccines given:								