

**NYC- Metro Physician Services, PC**

**271-11, 76th Avenue**

**New Hyde Parke, NY 11040**

**Inactive Vaccine Consent and Administration Record**

***Patient Information***

**Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth­­­­\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City. State, Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Care Provider (PCP) Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PCP Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PCP Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City. State, Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PCP Fax#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Race**: [ ] White [ ] Black or African American [ ] Asian [ ] Native Hawaiian or Pacific Islander

[ ] Native American or Alaskan [ ] Other

**Ethnicity:** [ ] Hispanic or Latino [ ] Non-Hispanic

|  |  |  |  |
| --- | --- | --- | --- |
| ***Screening Questions*** | | | |
| 1. Are you sick today? (For example: a cold, fever or acute illness) | Yes | No | Don’t Know |
| 2. Do you have allergies or reactions to any foods, medications, vaccines or latex? (For example: eggs, gelatin, neomycin, thimerosal, etc.) List\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Yes | No | Don’t Know |
| 3. Do you take anticoagulation medication? (For example: warfarin, Coumadin or other blood thinner) | Yes | No | Don’t Know |
| 4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g. diabetes), anemia or other blood disorder? | Yes | No | Don’t Know |
| 5. For women: Are you pregnant or nursing? Could you become pregnant during the next month? | Yes | No | Don’t Know |

|  |  |  |  |
| --- | --- | --- | --- |
| ***Insurance Information (To Be Completed by Patient or Authorized Person)*** | | | |
| Primary Insurance Name | Primary Insurance ID# | Subscriber Name/DOB | Subscriber Relation to Patient |
| Primary Insurance Address | Primary Insurance Group # | Primary Insurance Phone # | |

***CONSENT FOR SERVICES*:** I have been provided with the Vaccine Information Sheet(s) corresponding to the vaccine(s) that I am receiving. I have read or have had explained to me the information provided about the vaccine I am to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I request that the vaccine be given to me or to the person named above for whom I am authorized to make this request.

***AUTHORIZATION TO REQUEST PAYMENT:***I do hereby authorize NYC- Metro Physician Services, PC to release information and request payment. I certify that the information given by me in applying for payment under Medicare or Medicaid is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf.

***DISCLOSURE OF RECORDS:***I understand that NYC- Metro Physician Services, PC may be required to or may voluntarily disclose my health information to the physician responsible for this protocol of specific health information of people vaccinated at NYC- Metro Physician Services, PC (if applicable), my Primary Care Physician (if I have one), my insurance plan, health systems and hospitals, and/or state or federal registries, for purposes of treatment, payment or other health care operations (such as administration or quality assurance). I also understand that NYC- Metro Physician Services, PC will use and disclose my health information as set forth in the NYC- Metro Physician Services, PC Notice of Privacy Practices (copy is available in-clinic, online or by requesting a paper copy).

**Signature of Parent/Guardian/Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship to Patient** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Vaccine Administration Information***

Administration Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Vaccine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Manufacturer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lot #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Route: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Administration Site [ ] Left Deltoid [ ] Right Deltoid [ ] Left Thig [ ] Right Thigh

Dosage [ ] 0.5 ml [ ] 0.25 ml

VIS Version Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date VIS Given to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] I have provided the patient (and/or parent, guardian or surrogate, as applicable) with information about the vaccine and consent to vaccination was obtained.

Administering Immunizer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Administering Immunizer Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_