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

**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.

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 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 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**

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Lot #</th>
<th>Exp. Date</th>
<th>Site &amp; Route</th>
<th>Funding: 317 or State</th>
<th>Date of VIS</th>
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Vaccinator (print name): __________________________ Signature: __________________________ Date of Service: __________________________

Title of Vaccinator: __________________________ VFC Pin#: __________________________ Date VIS Given: __________________________

Date NMSIIS Entered: __________________________ Date TransactRx Entered: __________________________

Address/location of vaccines given: