Central Montana Health District
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Proudly Serving Golden Valley, Judith Basin, Musselshell, Petroleum, and Wheatland Counties

Adult Immunization Consent Form

Name: _____ **Date of Birth:** _____

Phone Number: _____

Insurance: _____

Consent for Vaccination

I, the undersigned, give my consent to receive the vaccines indicated below. I understand that:

- The vaccines listed protect me from serious diseases.
- Mild side effects (soreness, fever, fatigue) may occur.
- I may refuse any vaccine or ask questions before administration.
- I have received or have access to information about each vaccine, including benefits and risks.
- **We cannot immunize without your consent.**

Vaccine Consent Table

Please initial next to each vaccine you would like to receive:

☐ **Initial Vaccine**

_____ COVID-19

_____ Hep A

_____ Hep B (ages 19-59)

_____ HPV (ages 19-26)

_____ Influenza/Flu

_____ Pneumococcal (aged 50+)

_____ Shingles (aged 50+)

_____ Tdap

_____ _____

_____ _____

_____ _____

Acknowledgment & Signature

I acknowledge that I have read and understand the information above and give my consent to receive the vaccines I have indicated by my initials.

Name (Print): _____

Signature: _____ **Date:** _____

Working together to bring Health & Wellness to Central Montana!

Screening Checklist for Contraindications to Vaccines for Adults

YOUR NAME _____

DATE OF BIRTH _____/_____/_____
month day year

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 we need to ask you more questions. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Are you sick today?	☐	☐	☐
2. Do you have allergies to medications, food, a vaccine component, or latex?	☐	☐	☐
3. Have you ever had a serious reaction after receiving a vaccine?	☐	☐	☐
4. Do you have any of the following: a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak? Are you on long-term aspirin therapy?	☐	☐	☐
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
6. Do you have a parent, brother, or sister with an immune system problem?	☐	☐	☐
7. In the past 6 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?	☐	☐	☐
8. Have you had a seizure or a brain or other nervous system problem?	☐	☐	☐
9. Have you ever been diagnosed with a heart condition (myocarditis or pericarditis) or have you had Multisystem Inflammatory Syndrome (MIS-A or MIS-C) after an infection with the virus that causes COVID-19?	☐	☐	☐
10. In the past year, have you received immune (gamma) globulin, blood/blood products, or an antiviral drug?	☐	☐	☐
11. Are you pregnant?	☐	☐	☐
12. Have you received any vaccinations in the past 4 weeks?	☐	☐	☐
13. Have you ever felt dizzy or faint before, during, or after a shot?	☐	☐	☐
14. Are you anxious about getting a shot today?	☐	☐	☐

FORM COMPLETED BY _____ DATE _____

FORM REVIEWED BY _____ DATE _____

Did you bring your immunization record card with you? **yes** ☐ **no** ☐

It is important to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.