GCGHD
GALLIA COUNTY GENERAL HEALTH DISTRICT
GERALD E. VALLEE, M.D.
HEALTH COMMISSIONER/MEDICAL DIRECTOR

Public Health
Prevent. Promote. Protect.
Gallia County
Health Department

499 JACKSON PIKE, SUITE D, GALLIPOLIS, OHIO 45631-1398 • (740) 441-2018 • FAX (740) 441-2045 • gchd@galliacohealth.org

Adult Immunization Consent Form

Name: (Last)_____(First)_____(MI)_____

Birthdate:_____Age:_____Race:_____Phone:_____S.S. #_____

Address:_____City:_____State:_____Zip_____

□Private Insurance □Medicaid □Medicare □Insurance Does Not Cover Vaccines □No Insurance

Primary Insurance:_____Member ID:_____Group #:_____

Insured Name:_____Relationship to Insured:_____Insured S.S. #:_____

PLEASE ANSWER THE FOLLOWING QUESTIONS	YES	NO	EXPLAIN
1. Are you sick today?			
2. Do you have allergies to medications, food, or any other vaccine?			
3. Have you ever had a serious reaction after receiving a vaccine?			
4. Do you have cancer, leukemia, AIDS, or any other immune system problem?			
5. Do you take cortisone, prednisone, other steroids, or any cancer treatments?			
6. During the past year, have you received a transfusion of blood, or blood products, or been given a medicine called immune (gamma) globulin?			
7. For women: Are you pregnant or is there a chance you could become pregnant during the next month?			
8. Have you received any vaccinations in the past 4 weeks?			
9. Do you have a blood clotting disorder such as hemophilia or thrombocytopenia, or take anticoagulants (blood thinners)?			

I have read or have had explained to me the Vaccine Information Statement for the vaccines that I am about to receive today. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccines and request that it be given to me. I also authorize the release of immunization information to other health care agencies, schools, and place of employment at the discretion of the Health Department staff. I authorize the Health Department to bill for my service today. The presence of my signature certifies that I have received information on the HIPAA Privacy Notice.

_____ _____

Signature of Client/Authorized Guardian Date

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PLEASE COMPLETE SIDE TWO IF REQUESTING A TETANUS Diphtheria AND/OR PERTUSSIS VACCINE

(Td, Tdap)

Request for Tetanus Diphtheria and/or Pertussis Vaccine (Td, Tdap)

I, _____request that the nursing staff of the Gallia County Health Department administer the ADULT TETANUS DIPHTHERIA (Td) or TETNUS DIPHTHERIA AND PERTUSSISIS (Tdap) to me. I am requesting the vaccine due to an injury, contact with an infant, or due to need for routine vaccine. The nursing staff has informed me and I understand that this vaccine will not prevent or treat any bacterial infection I may contract from an injury. Further, they have recommended that I seek medical attention for actual wound treatment.

** PERSONS WHO ARE SENSTIVIE TO THIMEROSAL SHOULD NOT TAKE THE TETANUS/DITHERIA VACCINE**

□ 1. I have received the Tetanus vaccination series in the past.

□ 2. The date of my last booster was _____.

□ 3. I am unsure of the exact date, but I believe it has been longer than 10 years since my las TD shot. I have read the TD and Tdap Vaccine Information Statement and am aware that if given too often, a hypersensitivity to the vaccine could develop. I understand this could result in a massive local reaction at the vaccination site (painful swelling from shoulder to elbow).

I understand that the nurses and the Gallia County Health Department are not liable for any side effects I may experience from the vaccine. These possible side effects have been explained to me, and I voluntarily request that this vaccine be administered to me.

_____ _____

Signature of Client/Authorized Guardian Date

_____ _____

Witness Date

January 2019