GCGHD
GALLIA COUNTY GENERAL HEALTH DISTRICT
ETHAN STEPHENS, D.O.
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. I understand that if I have insurance and they do not pay for the service received today, I will receive a bill and be responsible to pay. The presence of my signature also certifies that I have received information on the HIPAA Privacy Notice.

_____ _____

Signature of Client/Authorized Guardian Date

January 2024

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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 2024