

GCGHD

GALLIA COUNTY GENERAL HEALTH DISTRICT
GLENN FISHER 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@galliahealth.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

June 2024

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 TETANUS DIPHTHERIA AND PERTUSSIS (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 SENSITIVE TO THIMEROSAL SHOULD NOT TAKE THE TETANUS/DIPHTHERIA 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 last 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