NMDOH
NEW MEXICO DEPARTMENT OF HEALTH

NEW MEXICO DEPARTMENT OF HEALTH ADULT VACCINE CONSENT FORM

This form is to be used for patients aged 19+ and older ONLY

Revised 08/2023

Last Name:_____ **First Name**:_____ **Middle Initial**:_____

Birth Date:_____ **Mother's Maiden Name**:_____

Month / Day / Year *First and Last Name*

Mailing Address:_____ **City**:_____ **State**:__NM____ **Zip**:_____

Daytime Phone:_____ **Responsible Person**:_____**Relationship**:_____

First and Last Name

Gender: ☐ Male ☐ Transgender ☐ Female ☐ Unknown

Race: ☐ American Indian/Native American/Alaskan Native ☐ Asian ☐ Other ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

INSURANCE INFORMATION – Fill the appropriate category – REQUIRED

Centennial Care/Medicaid: ☐ Blue Cross Blue Shield ☐ Presbyterian ☐ Western Sky

Policy/ Member ID #_____ Centennial Care Medicaid #: _____Group #:_____

Medicare Part B:

Subscriber ID #_____ Responsible Party:_____ Policy Holder's Date of Birth: _____

☐ No Insurance ☐ Private Insurance

MEDICAL SCREEING QUESTIONS - REQUIRED

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.	No	Yes	Don't Know
1. Are you sick today?			
2. Do you have allergies to medications, food, a vaccine component, or latex? Please list:			
3. Have you ever had a serious reaction to a vaccine in the past?			
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? Are you on long term aspirin therapy?			
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, monoclonal antibody or convalescent plasma, 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 to 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 insurance policy number to the NM Department of Health to allow the Department of Health to seek reimbursement for the vaccine and administrative costs. Unless I sign a statement signifying otherwise, I allow immunization information to be entered into the New Mexico Statewide Immunization Information System (NMSIIS) and be released to 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

Vaccine	Lot #	Exp. Date	Site & Route	Funding: 317 or State	Date of VIS

Vaccinator (print name):	Signature:	Date of Service:
Title of Vaccinator:	VFC Pin#:	Date VIS Given:
Entered into (Circle one): BEHR or Transact Rx **(cannot be both)** Date Entered:		Notes:
Address/location of vaccines given:		

DIRECT NMSIIS ENTRY OF VACCINES ADMINSTERED IS REQUIRED. FOR NM DOH OUTREACH ONLY: Data must be entered into TransactRx within 30 days of the date of service.

This form was designed for NM DOH public health offices use only. NM DOH is not responsible for data entry from outside health entities.

FOR CLINIC USE ONLY					
Vaccine	**Lot #**	**Exp. Date**	**Site & Route**	**Funding: 317 or State**	**Date of VIS**