Vaccine Consent Form

Please check the vaccine/vaccines that are required below.

- ❑ Hepatitis A (Adult)
- ❑ Hepatitis B (Adult)
- ❑ Influenza
- ❑ T/D & Pertussis (Adacel, tDap)
- ❑ Tetanus Diphtheria (Td)

For SC DHEC/SIMON registry, please indicate the following information:
Hispanic/Latino: (circle one) > YES or NO

Race: (circle one) > American Indian/Alaska Native, Asian, Black/African American, Native Hawaiin/Pacific Islander, White, Other race, Unknown, Decline to answer

Ethnicity: ____________________________(cultural identifier ie: *Mexican, Latin American, Bolivian, Dominican, etc*)

(Pediatric Patients Only) Patient's mother's maiden name (First & Last):______________________________________

1. Does the patient have a history of allergic reaction or allergies to latex, medications, food or vaccines (examples: polyethylene glycol, polysorbate, eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal)? YES or NO
   If yes, please list and describe allergy type:____
2. Do you feel sick today or had fever in last 24 hrs ? Yes/ No ____
3. Have you ever had a reaction after receiving a vaccination, including fainting or feeling dizzy? Yes/ No
4. Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-Barré syndrome (a condition that causes paralysis) or other nervous system problem? Yes/No______________________
5. Have you received any vaccinations or skin tests in the past eight weeks? Yes/No
   If Yes, please explain:____

I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient; or (c) a person authorized to consent on behalf of the patient where the patient is not otherwise competent or unable to consent for themselves. Further, I hereby give my consent to Redicare and the licensed healthcare professional administering the vaccine, as applicable (each an "applicable Provider"), to administer the vaccine(s) I have requested above. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine(s) and have received, read and/or had explained to me the VIS Sheet on the vaccine(s) I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. Further, I acknowledge that I have been advised that the patient should remain near the vaccination location for observation for approximately 15 minutes after administration. On behalf of the patient, the patient's heirs and personal representatives, I hereby release and hold harmless each applicable Provider, its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above. I acknowledge that: (a) I understand the purposes/benefits of my state's vaccination registry ("State Registry") and my state's health information exchange ("State HIE"); and (b) the applicable Provider may disclose my vaccination information to the State Registry, to the State HIE, or through the State HIE to the State Registry, or to any state or federal governmental agencies or authorities ("Government Agencies"), such as state, county, or local Departments of Health or the federal Department of Health and Human Services, the Centers for Disease Control and Prevention, or their respective designees as may be required by law, for purposes of public health reporting, or to my healthcare providers enrolled in the State Registry and/or State HIE for purposes of care coordination.

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Patient Name:____ Date of Birth: ________________________

Patient Signature (parent/guardian if minor): ____ Date: ________________

Relation:_______________________________

2/2/23 JB