Gateway Medical

Vaccine Consent Form

Name: _____ Date of Birth: _____/_____/_____

Age: _____ Gender: ❑ F ❑ M Phone Number: _____Ethnicity: ❑ Hispanic/Latino ❑ Not Hispanic/Latino

Race: ❑ American Indian/Alaska Native ❑ Asian ❑ Black/African American ❑ Native Hawaiian/Pacific Islander ❑ White

Address: _____ City: _____State: _____ Zip: _____

Primary Care Provider: _____ Phone: _____ Fax: _____

Please indicate YES or NO for each question.	YES	NO
Are you 18 years of age or older?		
Are you sick today? if YES, please answer the additional questions: Do you have a new fever? ____Yes ___No Do you have a cough? ____Yes ___No Do you have diarrhea? ____Yes ___No Have you been vomiting? ____Yes ___No		
Have you ever fainted or felt dizzy after receiving a vaccine?		
Have you ever had a reaction after receiving a vaccine?		
Do you have a long term health problem with heart disease, lung disease asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g. diabetes), or anemia or another blood disorder?		
Do you have a weakened immune system because of HIV/AIDS or another disease that effects the immune system, long-term treatment with drugs such as high-dose steroids or cancer treatment with radiation or drugs?		
Do you have allergies to latex, medications, food or vaccines? (Examples: eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal)		
Have you ever had a seizure disorder for which you are on seizure medications, a brain disorder, Guillain-Barre syndrome or other nervous system problems?		
For women: Are you pregnant or considering becoming pregnant in the next month?		

I have read, or had explained to me the Vaccine Information Statement on the vaccine I have elected to receive. I understand the risks and benefits, and have been provided an opportunity to ask questions, which have been answered to my satisfaction. I hereby give consent for the Gateway Medical, LLC staff to administer the vaccine requested and communicate the administration of the vaccine to my primary care practitioner, who is listed above. I authorize Gateway Medical to submit a claim to my insurer for the vaccine serum and the administration fee, and authorize an assignment of my insurance benefits under such claims to Gateway Medical. I will be financially responsible for any copays, coinsurance and deductibles for the requested services. I authorize Gateway Medical to use and/or disclose information about me, including any medical related information that I provide, or that is created or received by Gateway Medical that Gateway Medical reasonably determines is necessary to receive payment for its services, carry out my treatment or conduct its healthcare operations. Gateway Medical, the administering representative, and _____(location of vaccine clinic) shall not, at any time, or to any extent allowable by law, be liable, responsible, or in any way be accountable for any loss, injury, death, or damage suffered or sustained by me at any time in connection with, or as a result of, the administration of the requested vaccine. By signing below, I certify that I am the patient or the patient's guardian/personal representative signing on behalf of the patient, and that I have read, understand and agree to all statements on this form.

Signature of Patient/Legal Guardian: _____

Relationship:_____ Date:_____

For Healthcare Provider Use Only

Billing (select one) ❑ Cash ❑ Medicare ❑ Commercial ❑ MSA Employee: Location#_____-_____

Plan Name:_____ Phone: _____

Group #:_____ID#: (including alpha) _____

Vaccine	Lot#	Expiration	Manufacturer	Dose	Route	Site Given	Date on VIS
					IM	L / R deltoid	

Signature of Clinician: _____ New patient: ❑ Yes ❑ No

Title & License #: _____ Date: _____

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