Immunization Assessment and Promotion (IAP) Program

Vaccine Consent Form for Adults 19 and Older

Patient Information

Contact and Demographic Information

First Name	MI	Last Name	Maiden Name

Age YR	DOB (MM/DD/YY)	Weight LB	Sex ☐M ☐F ☐Other	Address

Race

☐Asian ☐American Indian or Alaska Native ☐Black or African American

☐Native Hawaiian or Other Pacific Islander ☐Other

☐Unknown ☐White

City	State	ZIP Code

Primary Phone (###) ###-####

Ethnicity

☐Not Hispanic or Latino ☐Hispanic or Latino

Email

Health Insurance Status

Required information. SRHD does not bill.

☐Uninsured ☐Underinsured

Screening Questions

		YES	NO	DON'T KNOW
1.	Are you sick today? (fever above 101 °F)	☐	☐	☐
2.	Do you have allergies to any medications, food, a vaccine component, or latex? (anaphylactic reaction, hives, swelling, respiratory distress, wheezing)	☐	☐	☐
3.	Have you ever had a serious reaction after receiving a vaccine?	☐	☐	☐
4.	Do you have any of the following: a long-term health problem with heart (including pericarditis or myocarditis), lung, kidney, or metabolic disease (diabetes), asthma, a blood disorder (including taking blood thinners), no spleen, complement component deficiency, Multisystem Inflammatory Syndrome (MIS-C or MIS-A) a cochlear implant, or a spinal fluid leak?	☐	☐	☐
5.	Are you on long-term aspirin therapy?	☐	☐	☐
6.	Do you currently smoke, vape, or use marijuana products?	☐	☐	☐
7.	Do you have cancer, leukemia, HIV, or any other immune system problem?	☐	☐	☐
8.	Do you have a parent, brother, or sister with an immune system problem?	☐	☐	☐
9.	In the past six months, have you taken medications that affect your immune system such as prednisone or other steroids; anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?	☐	☐	☐
10.	In the past year, have you received immune (gamma) globulin, blood or blood products, or an antiviral drug?	☐	☐	☐
11.	Have you received any vaccinations in the past four weeks? If so, which one(s)?	☐	☐	☐
12.	Have you had a seizure or a brain or other nervous system problem?	☐	☐	☐
13.	For females: Are you pregnant, or is there a chance you could become pregnant during the next month?	☐	☐	☐
14.	Are you anxious about getting a vaccine today?	☐	☐	☐

Office Use Only

Medical Screener Initials		Immunization record in IIS?	Yes	No
		Required VIS offered (please circle)	Yes	No

Consent

I have had explained to me the above information and was offered a copy of the Vaccine Information Statement and understand Spokane Regional Health District's (SRHD) Privacy Policy. I have had a chance to ask questions, which were answered to my satisfaction. I consent to the inclusion of this data in the Washington State Immunization Information (IIS) Registry. I believe I understand the benefits and risks of the vaccines checked on page two and request that the vaccine be given to me. Also, by signing this consent, I give permission for myself to be filmed or photographed during the immunization clinic today.

Signature	Date	Consent Obtained By Staff	
		☐Yes	Staff Initials
Check One ☐Patient ☐Guardian ☐Caregiver ☐Staff		Date	Time a.m./p.m.

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Office Use Only Adult Vaccines

Screener Recommendation

Antigen/VIS Publication Date

☐ COVID-19 / 01.31.25	☐ Hep A / 01.31.25	☐ Mpox / 01.31.25	☐ HPV 9 / 08.06.21	☐ Influenza / 01.31.25
☐ MMR / 01.31.25	☐ Hep B / 01.31.25	☐ Polio / 01.31.25	☐ PCV* / 05.29.25	☐ Tdap / 01.31.25
☐ Zoster* / 02.04.22				

Vaccines Administered

Vaccine	Ages	Trade Name	Manufacturer	Lot#	Exp. Date	Site Administered		Route
	(YEARS)			PLEASE WRITE CLEARLY.		PLEASE CIRCLE.		
HEP A/B	19+	Twinrix	GSK			LA	RA	IM
HEP A	19+	Vaqta	Merck			LA	RA	IM
HEP B	19+	Heplisav-B	Dynavax			LA	RA	IM
HPV9	19-45	Gardasil	Merck			LA	RA	IM
Influenza (Flu)	19+					LA	RA	IM
MMR	19+	MMR II	Merck			LA	RA	SQ/IM
Polio/ IPV	19+	IPOL	Sanofi			LA	RA	IM
PCV20	50+*	Prevnar 20	Pfizer			LA	RA	IM
Mpox	19+	JYNNEOS	Bavarian Nordic			LA	RA	SQ / IM
Tdap	19+	Boostrix	GSK			LA	RA	IM
Zoster*	50+*	Shingrix	GSK			LA	RA	IM
COVID-19	19+	Spikevax	Moderna			LA	RA	IM

*19 years and older for certain health indications.

Vaccinator's Information

Name: _____ **Credentials:** _____

Please print your information clearly.