First Person Care Clinics
Community Health & Wellness Center

	PRIVATE		317		VFC		COCOON

Office Use Only

Immunization Consent

Last(Apellido): _____ First (Primer Nombre): _____ MI(Inicial): ____
Date of Birth (Fecha de Nacimiento): ____/____/____ □Male/Masculino □Female/Femenina
Address(Dirreccion): _____ City (Ciudad): _____ State(Estado): ___ Zip(Postal): _____
Phone (Telefono): (____) _____-_____

1) Do you have Health insurance/coverage? Tienes seguro medico? □ Yes/Si □ No
2) If yes, which insurance? Si es asi, tipo de seguro? □ NV Medicaid/Check-up □ Private Insurance
   Insurance Name/nombre de seguros: _____
   Policy number/numero de poliza: _____
   Continue to Questions 3 – 4 if you have private insurance/Continuar en la preguntas 3-4 si tiene seguro privado:
3) Does your insurance cover vaccines? Su saguro cubre vacunas? □ Yes/Si □ No
4) If yes, which vaccines are covered? Se es asi, cuales vacunas cubre su seguro?

_____

The Following Questions will help us determine which vaccines may be administered today. If a question is not clear, please ask the clinic staff or providers for assistance.	**Yes Si**	**No**	**Unknown**
Are you sick today? Esta el pasiente enfermo hoy?			
Do you have any allergies to dairy or poultry products? (e.g. Eggs) Tiene alguna alergia a lacteos o productos avicolas?			
Have you received any vaccines in the past 4 weeks? Ha recibido alguna vacuna en las ultimas cuatro semanas?			
Have you had any adverse reactions to any administered vaccines? Ha tenido alguna reaccion adversa a algun vacunas administradas?			
Do you have a neurological disorder such as seizures or other disorders that affect the brain or have had a disorder that resulted from a vaccine? (e.g. Guillain-Barre Syndrome) Tiene un trastorno neurologico como convulsions o otros trastornos que afectan el cerebro o han tenido un trastorno que fue affectado por una vacuna?			
Do you have cancer, leukemia, AIDS, or any other immune system issues? Tiene cancer, leukemia, SIDA o cualquier otro problema del Sistema immune?			
Do you take prednisone, other steroids, or anti-cancer drugs or had any radiation treatments? Usted toma prednisone, otros esteroides o medicamentos contra el cancer o ha tenido algun tratamiento de radiacion?			
Within the past year, have you received a transfusion of blood or blood products, including antibodies? En el ultimo ano, ha recibo una transfusion de sangre o productos sanguineos, incluyendo los anticuerpos?			
Do you have asthma? Tiene Asma?			
<u>For women:</u> Are you pregnant or could you become pregnant in the next three months? Esta embarazada o podria quedar embarazada en los proximos tres meses?			

The above signed as a patient or parent/legal guardian of the above named individual, hereby requests immunizations by First Person Care Clinics. I hereby fully consent to such immunizations and agree that: data collected will be entered into Nevada WebIZ in compliance with all state laws. The above signed is solely responsible for follow-up or any and all abnormalities and findings and hereby fully releases First Person Care Clinics et. Al. from any liability which may arise from the screenings, treatment, procedures, diagnosis and/or from any information found during today's and all subsequent future visits.

- Lo anterior firmó como paciente o padre / tutor legal de la persona nombrada anteriormente, solicita a las vacunas de First Person Care Clinics. Por la presente autorizo plenamente a tales vacunas y acepto que: Los datos recogidos serán incluidos en Nevada WeBIZ en cumplimiento con todas las leyes estatales. Lo anterior firmado es el único responsable de seguimiento o cualquier y todas las anomalías y los hallazgos y los estrenos de este medio plenamente Primera Persona Clínicas de Atención et. Al. de cualquier responsabilidad que pudiera derivarse de la detección, el tratamiento, los procedimientos, el diagnóstico y / o de cualquier información que se encuentra en el actual y todas las futuras visitas posteriores.

Patient or Parent/Guardian Signature: _____ Date: _____

Print Name of Signee: _____ Print Name of Patient: _____

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TO BE COMPLETED BY FIRST PERSON CARE CLINIC STAFF

Patient WebIZ number: _____

□ VIS Given (Initial_____) □ Official Record Given (Initial_____) □ Date Entered in WebIZ: (_____/_____/_____)

Vaccine	Date Given	Mfg/Lot #	Site	Route	VIS Date	Administered by: (Name and Title)
DTaP			LD RD LT RT		05/17/2007	
Hepatitis A			LD RD LT RT		10/25/2011	
Hepatitis B			LD RD LT RT		02/02/2012	
HiB			LD RD LT RT		04/02/2015	
HPV-9			LD RD LT RT		04/15/2015	
MCV4			LD RD LT RT		10/14/2011	
MMR			LD RD LT RT		04/20/2012	
MMRV			LD RD LT RT		04/20/2010	
PCV-13			LD RD LT RT		02/27/2013	
PPSV-23			LD RD LT RT		04/24/2015	
Polio			LD RD LT RT		11/08/2011	
ROTA			LD RD LT RT		04/15/2015	
Shingles			LD RD LT RT		10/06/2009	
Tdap			LD RD LT RT		02/24/2015	
Td			LD RD LT RT		02/24/2015	
Varicella			LD RD LT RT		03/13/2008	
Influenza (VFC) (3 years+)		Fluarix / 4JY49	LD RD LT RT		08/07/2015	
Influenza (VFC) (2 years-49 years)		FluMist / FJ2073	Nasal	Nasal	08/07/2015	
Influenza (VFC) (6mons-35mons)		FluZone / U5319DA	LD RD LT RT		08/07/2015	
Influenza (Private)			LD RD LT RT		08/07/2015	

Reviewed by: □ Jeffrey L. Brown, D.O. □ Adriene Rivera, APRN □ Minnie Wood, APRN □ Ferdinand R. Madayag, APRN

□ Other: _____/ Title: _____ Date Reviewed: _____/_____/_____

Notes:

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Provider Signature: _____

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