IMMUNIZATION CONSENT FORM

Date	Clinic Site	Patient Chart/Weblz No.	Vaccinator/Title

Vaccine	Dose # 1	2	3	4	5	Route	Dosage	Site: RA, LA RT, LT	Lot #	Mfr.	VIS date
Combination: **Circle Combo** DTaP / HIB / IPV / Hep A / Hep B						IM					
DTaP						IM					
Hepatitis A						IM					
Hepatitis B						IM					
HIB						IM					
HPV						IM					
Influenza						IM					
Meningococcal Conjugate- MCV4						IM					
MMR						SC					
Pneumococcal Conjugate- Prevnar 13						IM					
Polio (IPV)						IM●SC					
Rotavirus						ORAL					
Td						IM					
Tdap						IM					
Varicella						SC					
Pneumococcal Adult						IM●SC					
OTHER:											
❑ PPD Date read: Results:						ID	0.1				

Patient Information

Patient: Last Name First Name Middle	Social Security No.	DOB:	Age:	Sex: ❑ Male ❑ Female

Mailing Address:	Home phone number: Other Contact number:	Ethnicity: ❑ Chamorro ❑ Filipino ❑ African-American ❑ Caucasian ❑ Chuukese ❑ Marshallese ❑ Yapese ❑ Palauan ❑ Kosraen ❑ Pohnpean ❑ Korean ❑ Japanese ❑ Chinese ❑ Vietnamese ❑Other:_____	Insurance: ❑ Medicaid ❑ MIP ❑ No Insurance ❑ Calvo's ❑ Staywell ❑ Nanbo's ❑ FHP/Takecare ❑ Multicover ❑ Military ❑ Medicare ❑ BC/BS ❑Other:_____ ❑ Moylans's/ NetCare

Mother: Last Name First Name Middle Name	Mother's Maiden Name

Father: Last Name First Name M.I	Authorized Guardian (with written or legal consent) Print Name/Signature:

Consent to IIS

I, the undersigned, hereby give my full consent to _____to perform vaccination procedures for the maintenance of myself or my child's good health. I also consent to the entry of my or my child's demographic and immunization information into the Guam Immunization Information System (GUWebIZ). This information may be shared between health providers to ensure a current and accurate immunization record.

Patient Eligibility Screening Record Vaccines for Children Program

1. Is your facility a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC)? ❑Yes ❑ No
2. Primary Provider's Clinic: _____
3. Does this patient qualify for immunization through the VFC Program because he/she (check only one box):
   ❑ Is in Medicaid ❑ Has no health insurance ❑ Is an American Indian or Alaskan Native ❑Is underinsured (has health that does not pay for vaccinations)*
   ❑ No, this child does not qualify for immunization through the VFC Program because he/she does not meet the eligibility criteria.

*To be supported with VFC Purchased vaccine, underinsured children must be vaccinated through a FQHC or RHC or under a deputized agreement with an approved provider.

CONSENT FOR HEALTH SERVICES

I, the undersigned, understand that I will be fully informed of the need, risks, and advantages of each medical procedure and treatment, and do hereby give my free and full consent to the Department of Public Health and Social Services (DPHSS) to perform such necessary examinations and treatment deemed advisable in connection with my diagnosis and the maintenance of good health. I also understand that I have the right to refuse such care, unless required by law. I understand that it is my responsibility to supply accurate and complete medical history information to those involved with my care, and to inform them of any changes in my health. I also understand that it is my responsibility to inform those involved with my care if I do not understand any instructions given or cannot follow them. This consent, unless sooner revoked in writing, shall expire upon my discharge by appropriate authorities of DPHSS.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided the Department of Public Health and Social Services (DPHSS) Notice of Privacy Practices.

- It tells me how DPHSS will use my health information for the purposes of treatment, payment for my treatment, and health care operations.
- It explains in more detail how DPHSS may use and share my health information for other purposes other than treatment, payment, and health care payment.
- It tells me how DPHSS will use and share my health information as required/permitted by law.
- It explains my individual rights in regards to my health information.
- If I am a DPHSS consumer receiving health services, I consent to DPHSS using and disclosing my treatment and medical records maintained by DPHSS for the purpose detailed in the Notice of Privacy Practices.

_____ Signature (Patient/Parent/Guardian) / Date

_____ Witness Signature / Date