



NEW MEXICO DEPARTMENT OF HEALTH ADULT VACCINE CONSENT FORM

This form is to be used for patients aged 19+ and older ONLY

Revised 01/2019

Last Name: First Name: Middle Initial: Birth Date: Mother's Maiden Name: Mailing Address: City: State: Zip: Daytime Phone: Responsible Person: Relationship:

Gender: Male Female Race: American Indian/Alaskan Native Asian Other Black/African American Native Hawaiian/Pacific Islander White Ethnicity: Hispanic Non-Hispanic

INSURANCE INFORMATION - Fill the appropriate category - REQUIRED

Centennial Care/Medicaid: Blue Cross Blue Shield Presbyterian Western Sky Policy/ Member ID # Centennial Care Medicaid #: Group #: Medicare Part B: Subscriber ID # Responsible Party: Policy Holder's Date of Birth: No Insurance Private Insurance

MEDICAL SCREENING QUESTIONS - REQUIRED

Table with 4 columns: Question, No, Yes, Don't Know. Contains 10 screening questions regarding health status, allergies, and medical history.

CONSENT FOR VACCINATION

I have been given and have read or have had explained to me, the information in the Vaccine Information Statement(s) for the diseases and vaccine(s) checked below. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine requested and ask that the vaccine checked below be given to me or the person named for whom I am authorized to make this request.

Signature (Client/Guardian): Date:

FOR CLINIC USE ONLY

Table with 6 columns: Vaccine, Lot #, Exp. Date, Site & Route, Funding: 317 or State, Date of VIS. Includes fields for Vaccinator name, Signature, Date of Service, Title, VFC Pin#, Date VIS Given, Date NMSIS Entered, Date TransactRx Entered, Notes, and Address/location of vaccines given.