|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Name of Patient (Last Name, First Name):** | | | | **Mother’s Maiden Name:** | **Social Security Number:**  (last 4 digits) | | |
| **Date of Birth:** | **Sex:** | | **Race: Hispanic: YES/NO** | **Country of Birth:** | **Preferred Language:** | | |
| **Address:** | | | | **City/State/Zip:** | | | |
| **Contact Phone:** | | **Medicaid/Medicare #** | | **Parent/Guardian Names** (if a minor**):** | | | |
| **Acknowledgement of Receipt of Notice of Privacy Practice** | | | | | | | |
| I understand that as a part of the provision of health care services, Brazos County Health Department creates and maintains health records and other information describing among other things, my health and medical history, symptoms, examination, and test results, diagnosis, treatment and plans for future care or treatment.  I have been offered an opportunity to review or have reviewed the Brazos County Health Department’s Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that Brazos County Health Department reserves the right to change its Notice and practices with regard to the use and disclosure of health information. I understand that I have the right to request restriction as to how my health information may be used or disclosed for treatment, payment or healthcare operations, but that Brazos County Health Department is not required to agree to the requested restrictions. | | | | | | | |
| **Medical Assessment Questionnaire for Immunizations** | | | | | | | |
| **Please read over the following questions, if you have a question or a question is not clear, please ask the nurse.** | | | | | | **YES** | **NO** |
| 1. Is the patient sick today? | | | | | |  |  |
| 1. Does the patient have allergies to medications, food or any vaccine or Asthma? List allergy: | | | | | |  |  |
| 1. Has the patient had a reaction to a vaccine in the past? | | | | | |  |  |
| 1. Has the patient had a seizure or a brain problem or has the patient ever been diagnosed with Guillain-Barré Syndrome? | | | | | |  |  |
| 1. Does the patient have cancer, leukemia, AIDS, or any other immune system problem? | | | | | |  |  |
| 1. Has the patient taken cortisone, prednisone, other steroids, or anti-cancer drugs or has x-ray treatments in the past 3 months? | | | | | |  |  |
| 1. Has the patient received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin in the past year? | | | | | |  |  |
| 1. **For Children**: Does the patient have (or had) a disease of the stomach or intestines? | | | | | |  |  |
| 1. **For Women:** Is the patient pregnant or is there a chance she could become pregnant in the next 4 weeks? | | | | | |  |  |
| 10. Has the patient received vaccinations in the past 4 weeks? Name of vaccine? | | | | | |  |  |
| **TB Skin Testing** | | | | | | | |
| 1. Date and Result of last TB skin test? | | | | | | | |
| 2. Does the patient have a history of treatment of TB infection or disease? | | | | | |  |  |
| Reason for TB skin Test (please circle): Work School Exposure Other: | | | | | | | |
| **Consent for Medical Services** | | | | | | | |
| 1. I agree that the person named above will get the vaccine(s). 2. I have received or was offered a copy of the Vaccine Information Statements (VIS) for each vaccine. 3. I know the risk of the disease these vaccines prevent. I know the benefit and risk of the vaccines. 4. I have and had a chance to ask questions about the disease(s), the vaccine(s), and how the vaccines will be given. 5. I know that the person named above will have a vaccine put in his or her body to prevent the disease(s) the vaccines prevent. 6. I am an adult who can legally consent for the person named above to get vaccines. I freely and voluntarily give my signed permission for these vaccines. 7. I authorize the Brazos County Health Department to release past, present and further immunization records on my child to a parent of the child and any of the following: local or regional health department, ImmTrac, physician to the child, school in which the child is enrolled/and or child care facility in which the child is enrolled. If patient is18 years or older, authorizes release of records to self, patient’s physician, school and/or institution of higher learning in which patient is enrolled. 8. I have been counseled by a Health Care Professional on the side effects of vaccines and the vaccines recommended and required by State Guidelines.   Signature below represents the patient’s / or patient’s parent/guardian has had an opportunity to review the “Notice of Privacy Practices”, has completed the Medical Assessment, and is “Consenting for Medical Services” as listed above.  Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |