VAX 4 LIFE
A STEP IN THE DIRECTION OF BETTER HEALTH

RX #: _____

Vaccination Screening/Consent Form

NORTH CENTRAL DISTRICT HEALTH DEPARTMENT
422 E. DOUGLAS STREET, O'NEILL, NE 68763
MON-FRI 8:00 AM - 4:30 PM 402-336-2406

NCDHD North Central District Health Department

LAST NAME	FIRST NAME	MIDDLE NAME	MAIDEN NAME

AGE	BIRTHDATE	GENDER	MOTHER'S MAIDEN NAME (First & Last)*
		☐ FEMALE ☐ MALE	

STREET ADDRESS	MAILING ADDRESS (IF DIFFERENT)

CITY	STATE	ZIP	PHONE #
			( ) -

*Used to Verify Recipient in NESIIS
☐ Phone number accepts texts

1 Are you sick today? ☐ YES ☐ NO

2 Do you have allergies to medications, gelatin, yeast, eggs, latex or any vaccine? ☐ YES ☐ NO

3 Have you ever had a serious reaction to a vaccine in the past? ☐ YES ☐ NO

4 Have you ever had a seizure or a neurological problem? ☐ YES ☐ NO

5 Have you ever had Guillian-Barre syndrome? ☐ YES ☐ NO

6 For children 8 years and younger: Is this the first time he/she has received an Influenza vaccine? ☐ NA ☐ YES ☐ NO

INSURANCE QUESTIONS: Please bring insurance card or a copy of the front and back of the insurance card with you.

☐ You can text a copy of your insurance card to (402) 961-1718, check the box if you choose this option.

☐ Private Insurance-Vaccine Covered ☐ Private Insurance-Vaccines NOT covered ☐ Heritage Health/Medicaid ☐ American Indian/Alaska Native ☐ Medicare ☐ No Insurance ☐ Vaccine relinquished to other entity.

If submitting to insurance, who is the primary policy holder? *Name as it appears on the card:* _____ ***Insurance*** _____

Policy/Member/ID #: _____

Fill out the shaded areas if the ***Recipient is NOT the policyholder*** **.**

Policyholder's Mailing Address _____

City _____ State _____ Zip _____

Policyholder Gender: M F Policyholder's Birthdate: _____

Relationship to policyholder: ☐ Spouse ☐ Child ☐ Other

Policyholder's phone #: ( ) -

I GIVE CONSENT to North Central District Health Department (NCDHD) and its staff to vaccinate the person in this record. I have received and read or had explained to me the Vaccine Information Statement(s) or Emergency Use Authorization(s) and I understand the benefits and risks of the vaccine(s) and their presently known side effects. Furthermore, I understand that there is no guarantee of immunity or that the client will not experience an adverse reaction to the vaccine(s). In the event of adverse side effects or that immunity does not occur, I hereby hold NCDHD harmless for any and all liability to the extent permitted under the law. If the person named above is under 19 and is not accompanied by an adult, I agree to allow the school agent or NCDHD agent to act on my child's behalf. I also acknowledge that NCDHD has made their Notice of Privacy available for review. I understand that I may request a copy of the Notice of Privacy. NCDHD's Notice of Privacy Practices provides information about how NCDHD may use or disclose protected health information, including electronic protected health information. Protected health information may be disclosed or used for treatment, payment, or healthcare operations. I hereby grant permission to NCDHD to release any pertinent information to the insurance carrier listed upon request and any physicians to whom I might be referred. If not eligible for Vaccines for Children Program (VFC) or Vaccines for Adults (VFA), I understand that I am responsible for charges not paid by my insurance company. All vaccines administered by NCDHD will be entered into NESIIS (Nebraska State Immunization Information System). I give consent for the vaccinations requested to be given to me (or the person named above for whom I am authorized to make this request and provide surrogate consent). I also give consent for the following: (check YES or NO)

1 I authorize NCDHD to release information from the client's medical record re: immunization status to the following entities: client family/guardians/representatives, child care, school or work-related authorities. ☐ YES ☐ NO

2 I authorize NCDHD to photograph me and/or my child(ren) during the services provided and utilize the image(s) for publishing and/or distribution. ☐ YES ☐ NO

X **Patient Signature: *if recipient is under 19, a parent or guardian must sign consent** **Date:**

If recipient is under 19 this section must be filled out: Emergency Contact information

Emergency Contact Name (please print): _____ Emergency Contact Phone #: ( ) -

WE REQUEST THAT YOU STAY ON SITE FOR 15 MINUTES AFTER RECEIVING YOUR VACCINATION(S). IF YOU CHOOSE TO LEAVE, YOU ASSUME ALL RESPONSIBILITY/LIABILITY FOR ANY ADVERSE EVENT. THANK YOU.

Revised by: JLB, April 2025