LINCOLN COUNTY PUBLIC HEALTH
418 Mineral Ave | Libby, MT 59923
(406) 283-2447
www.lincolnmthealth.com

CONSENT FOR VACCINE AND imMTrax FORM

Patient Name:_____ DOB: _____

M. Address:_____City:_____State:____MT____

Zip Code:_____ Phone:_____ County: _____Lincoln_____

Vaccine(s) to administer:_____

Please carefully read and answer the following questions for the person receiving a vaccine:

1.	Is the person sick today?	YES	NO
	a. If yes, what are your symptoms?		
2.	Is the person allergic to any food, medicine, preservative or latex?	YES	NO
3.	Has the person had any adverse reactions to previous vaccines?	YES	NO
4.	Does the person have a medical condition that affects their immune system?	YES	NO
5.	Has the person received any blood products in the past year?	YES	NO
6.	Is the person pregnant?	YES	NO
7.	Has the person received any vaccinations in the past 30 days?	YES	NO
8.	Is this person enrolled in WIC?	YES	NO

imMTrax Consent

By signing below, I authorize my health care provider and public health agency to collect and enter my immunization records into the Department of Public Health and Human Services' Immunization Information System (II). The IIS is a confidential computer system that contains immunization records and is the primary medical record system that LCPH uses. I understand that information in the registry may be released to a public health agency as well as my health care providers to assist in my medical care and treatment. In addition, information may be released to schools or daycares in order to comply with immunization requirement. I understand that I can revoke this authorization and have my record removed at any time.

☐ Check here if you **DO NOT** wish to have your information on imMTrax.

Vaccine Consent

By signing below, I agree that I have read or have had explained to me the information about the vaccine(s) being administered. I have received the Vaccine Information Statement (VIS) for each of the vaccines indicated. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risk s of the vaccine(s) and ask the vaccine(s) be given to me or to the person named for whom I am authorize to make this request. I understand my financial obligation to pay the co-payments and deductible payments required by my insurance coverage and all charges for services not covered by my insurance plan.

Privacy Policy

By signing below, I agree that I have been offered or have read the LCPH Patient Privacy Policy and I understand my rights regarding my health information created or saved by LCPH. I also understand that in certain situations my health information may be shared without my consent as stated on the LCPH Patient Privacy Policy. I hereby agree and consent to the Patient Privacy Policy.

Patient/Guardian
Signature:_____Date:_____

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FOR PUBLIC HEALTH OFFICE ONLY

Vaccine: ______________________________________ Manufacturer:_________________________________

Lot #:____________________ **VFC** **VFA** **Private** Route: _____________ Location: ______________

Vaccine Expiration: ___________________________ Cost:_______________ Admin Fee:________________

Administered by: ____Riley M. Black, RN_____________ Initials: ____________ Date:__________________

Vaccine: ______________________________________ Manufacturer:_________________________________

Lot #:____________________ **VFC** **VFA** **Private** Route: _____________ Location: ______________

Vaccine Expiration: ___________________________ Cost:_______________ Admin Fee:________________

Administered by: ____Riley M. Black, RN_____________ Initials: ____________ Date:__________________

Vaccine: ______________________________________ Manufacturer:_________________________________

Lot #:____________________ **VFC** **VFA** **Private** Route: _____________ Location: ______________

Vaccine Expiration: ___________________________ Cost:_______________ Admin Fee:________________

Administered by: ____Riley M. Black, RN_____________ Initials: ____________ Date:__________________

BILLING

Total Amount Billed:________________________________ Date Billed:___________________________

Payment Method: CASH CHECK CREDIT/DEBIT INSURANCE COMPANY

Insurance Information:
Carrier: _________________________________ *Policy #:*____

*Policy Holder:*____ *Holder DOB:*__________________

Patient Relationship to Holder: *Self* *Child* *Spouse*

Total Payment Received:______________________________ Date Received:________________________