Randolph County Health Department

RSV (Respiratory Syncytial Virus) Assessment Screening and Consent Form

First name: ______________________________ Last name: ___________________________ Age: _______

Date of birth: ________________ SS # ___________________________ Phone: _______________________

Address: _____________________________City: _____________________ State: _______ Zip: __________

Email Address: ______________________________________ Sex: ◯ Male ◯ Female

Ethnicity: ◯ Hispanic ◯ Non-Hispanic ◯ Unknown

Race: ◯ American Indian or Alaska Native ◯ Asian ◯ Black or African American ◯ Native Hawaiian or Other Pacific Islander ◯ White

Insurance Plan and / or Network: ____

Insurance Id Number: ____ Group: __________________________

Are you insured under your parent/guardian's insurance plan? ◯ Yes ◯ No

Parent/Guardian First & Last Name (if covered under their plan): ____

Insured DOB: ________________________ Gender: ◯ Male ◯ Female Relationship ____________________

Please answer the following questions

- Are you sick today (cold, fever, cough, nausea/vomiting)? ◯ Yes ◯ No
- Do you have allergies to medications, food, a vaccine component, or latex? ◯ Yes ◯ No
- Have you ever had a serious reaction after receiving a vaccine? ◯ Yes ◯ No
- Do you have any of the following: a long-term health problem with heart, lung, kidney, or metabolic disease (e.g. diabetes), asthma, a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak? ◯ Yes ◯ No
- Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem? ◯ Yes ◯ No
- Do you have a parent, brother, or sister with an immune system problem? ◯ Yes ◯ No
- In the past 6 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis, or have you had radiation treatments? ◯ Yes ◯ No
- Have you had a seizure or a brain or other nervous system problem? ◯ Yes ◯ No
- In the past year, have you received immune (gamma) globulin, blood/blood products, or an antiviral drug? ◯ Yes ◯ No
- Are you pregnant? ◯ Yes ◯ No
- Have you received any vaccinations in the past 4 weeks? ◯ Yes ◯ No
- Have you ever felt dizzy or faint before, during, or after a shot? ◯ Yes ◯ No
- Are you anxious about getting a shot today? ◯ Yes ◯ No

Please Read and Sign Below

This record will be kept on file at the Randolph County Health Dept. It will record when the vaccine was given, the name of the manufacturer, the lot number, injection site, and who gave the injection. I have read and been offered a copy of the Vaccine Information Statement and have had the opportunity to ask questions and had them answered to my satisfaction. I understand the benefits and risk of the vaccine to be given and give my consent to receive the injection. I give consent for my insurance (if applicable) to be billed, and if denied, I understand that I am responsible for the payment in full. By signing below, I acknowledge that I have been offered a copy and/or read the HIPAA Privacy Act and agree to the statements above.

Signature ____ **Date:** __________________

Staff Use Only: Eligibility verified by Online or Phone (initials) _______________ Date: __________________

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