

IMMUNIZATION Client Registration Form

Jackson County Health Dept.
1715 Lansing Ave., Suite 221
Jackson, MI 49202

Receipt#: _____

Check #: _____ Cash _____

VISA/MC Auth Code: _____

Discover _____

Adm. Fee - \$23.00 x _____ = \$ _____

Private doses -	Vaccine type	Price
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

MCIR ID _____

VFC - M-Caid, Un-Insured,
Underinsured,
American Indian, Alaska Native
Private AVP
Non-VFC Medicaid (please circle one)

*Last 4 of SS for part D clients only

Name of Client (Last, First, Middle) - please print Shephard, Amber Dawn		<input checked="" type="checkbox"/> Female <input type="checkbox"/> Male	Client Birth Date 3 / 29 / 83 Age 38
Address City Zip 1246 N. Brown St. 49202		County Jackson	Telephone Home 517) 358-2629 Cell ()
Parent/Guardian name OR Maiden Name (Last, First, Middle)		Today's Approx. Weight: _____ lbs.	Relationship to client: (please circle) Parent Guardian Other
Does the client have Medicaid? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Medicaid # _____		Name of Client's Physician/Practice: DR. Baines	Race/Ethnicity: (please circle) American Indian Asian Black Hispanic <input checked="" type="checkbox"/> White Other _____
Does the client have other Insurance? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, does the insurance pay for immunizations? Yes <input type="checkbox"/> No <input type="checkbox"/>			

Screening Questions

The following questions will help us determine which vaccines may be given today.

If a question is not clear, leave it blank and the nurse will explain it.

	YES	NO	Don't Know
1. Is the client sick today, or have a fever?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the client have any allergies to medications, food, a vaccine component, or latex?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the client had a serious reaction to a vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the client had a health problem with lung, heart, kidney, or metabolic disease (e.g., diabetes), or a blood disorder? Is he/she on long-term aspirin therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Has the client been told by a health care provider that he/she has had wheezing or asthma in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Is the client a smoker?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. If the client is a baby, have you ever been told he or she has had intussusception?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Has the client, a sibling, or a parent had a seizure; has the client had brain or other nervous system problems? Has he/she ever had Guillain-Barre' syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Does the client have cancer, leukemia, HIV/AIDS, or any other immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. In the past 3 months, has the client taken medication that has weakened their immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments? Is he/she taking antiviral medications?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. In the past year, has the client received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Is the client pregnant or could she become pregnant during the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Has the client received vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I have received a copy of information about the vaccine(s) and the diseases they prevent. I have had a chance to ask questions and they were answered to my satisfaction. I understand the risks and benefits of the vaccine(s). I ask that the vaccine(s) be given to me or to the person for whom I am authorized to make this request. I also verify that all of the above information I supplied is correct to the best of my knowledge.

A. Shephard
Signature of client/parent/guardian/or person in loco parentis

11/24/21
Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices.

Print name of patient _____

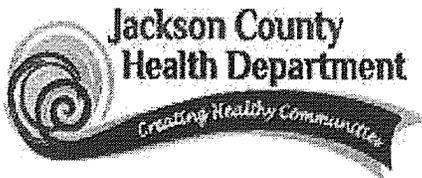
Signature of patient or personal representative _____

Office Use Only
Our practice will make a good faith effort to obtain a written acknowledgment of receipt of the Notice provided to the individual. If written acknowledgment is not obtained, our practice must document its good faith efforts to obtain such acknowledgment and record the reason why the acknowledgment was not obtained.

Please circle: Refused to Sign *Physically unable to sign
* Previously signed Other: _____

* Document program, if known: _____

Employee Signature _____ Date _____



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1715 Lansing Ave., Suite 221
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Receipt#: _____

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VISA/MC Auth Code: _____

Discover _____

Adm. Fee - \$23.00 x _____ = \$ _____

Private doses -	Vaccine type	Price
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

MCIR ID _____
 VFC - M-Caid, Un-Insured,
 Underinsured,
 American Indian, Alaska Native
 Private AVP
 Non-VFC Medicaid (please circle one)

*Last 4 of SS for part D clients only

Name of Client (Last, First, Middle) - please print <i>Eubanks Greg S.</i>	<input type="checkbox"/> Female <input checked="" type="checkbox"/> Male	Client Birth Date ____/____/____ Age ____
Address City Zip <i>411 Washington Jackson 49201</i>	County <i>Jackson</i>	Telephone Home () Cell (617) <i>392-6885</i>
Parent/Guardian name OR Maiden Name (Last, First, Middle)	Today's Approx. Weight: lbs.	Relationship to client: (please circle) Parent Guardian Other
Does the client have Medicaid? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Medicaid # _____ Does the client have other Insurance? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, does the insurance pay for immunizations? Yes <input type="checkbox"/> No <input type="checkbox"/>	Name of Client's Physician/Practice:	Race/Ethnicity: (please circle) American Indian Asian Black Hispanic White Other _____

Screening Questions

The following questions will help us determine which vaccines may be given today.

If a question is not clear, leave it blank and the nurse will explain it.

	YES	NO	Don't Know
1. Is the client sick today, or have a fever?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the client have any allergies to medications, food, a vaccine component, or latex?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the client had a serious reaction to a vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the client had a health problem with lung, heart, kidney, or metabolic disease (e.g., diabetes), or a blood disorder? Is he/she on long-term aspirin therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Has the client been told by a health care provider that he/she has had wheezing or asthma in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Is the client a smoker?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. If the client is a baby, have you ever been told he or she has had intussusception?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Has the client, a sibling, or a parent had a seizure; has the client had brain or other nervous system problems? Has he/she ever had Guillain-Barre' syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Does the client have cancer, leukemia, HIV/AIDS, or any other immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. In the past 3 months, has the client taken medication that has weakened their immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments? Is he/she taking antiviral medications?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. In the past year, has the client received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Is the client pregnant or could she become pregnant during the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Has the client received vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I have received a copy of information about the vaccine(s) and the diseases they prevent. I have had a chance to ask questions and they were answered to my satisfaction. I understand the risks and benefits of the vaccine(s). I ask that the vaccine(s) be given to me or to the person for whom I am authorized to make this request. I also verify that all of the above information I supplied is correct to the best of my knowledge.

Signature of client/parent/guardian/or person in loco parentis _____

Date _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
 By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices.

Print name of patient _____

Signature of patient or personal representative _____

Office Use Only

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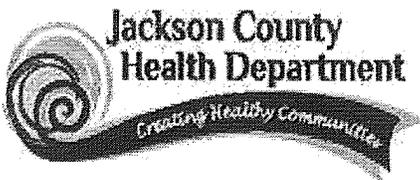
Please circle: Refused to Sign *Physically unable to sign

* Previously signed Other: _____

* Document program, if known: _____

Employee Signature _____

Date _____



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Discover _____

Adm. Fee - \$23.00 x _____ = \$ _____

Private doses -	Vaccine type	Price
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

MCIR ID _____
 VFC - M-Caid, Un-Insured,
 Underinsured,
 American Indian, Alaska Native
 Private AVP
 Non-VFC Medicaid (please circle one)

*Last 4 of SS for part D clients only
6296

Name of Client (Last, First, Middle) - please print Seffernick Susan Marie		<input checked="" type="checkbox"/> Female <input type="checkbox"/> Male	Client Birth Date <u>10 / 21 / 57</u> Age <u>64</u> Month Day Year
Address City Zip 3544 Bellrose Dr. Jackson 49201		County Jackson	Telephone Home () Cell (517) 937-6833
Parent/Guardian name OR Maiden Name (Last, First, Middle)		Today's Approx. Weight: <u>300 lbs.</u>	Relationship to client: (please circle) Parent Guardian Other
Does the client have Medicaid? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Medicaid # _____		Name of Client's Physician/Practice: Lissa Million	Race/Ethnicity: (please circle) American Indian Asian Black Hispanic White Other _____
Does the client have other Insurance? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> If Yes, does the insurance pay for immunizations? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			

Screening Questions

The following questions will help us determine which vaccines may be given today.

If a question is not clear, leave it blank and the nurse will explain it.

	YES	NO	Don't Know
1. Is the client sick today, or have a fever?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Does the client have any allergies to medications, food, a vaccine component, or latex?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Has the client had a serious reaction to a vaccine in the past?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Has the client had a health problem with lung, heart, kidney, or metabolic disease (e.g., diabetes), or a blood disorder? Is he/she on long-term aspirin therapy?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Has the client been told by a health care provider that he/she has had wheezing or asthma in the past 12 months?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Is the client a smoker?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. If the client is a baby, have you ever been told he or she has had intussusception?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8. Has the client, a sibling, or a parent had a seizure; has the client had brain or other nervous system problems? Has he/she ever had Guillain-Barre' syndrome?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9. Does the client have cancer, leukemia, HIV/AIDS, or any other immune system problem?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
10. In the past 3 months, has the client taken medication that has weakened their immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments? Is he/she taking antiviral medications?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
11. In the past year, has the client received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
12. Is the client pregnant or could she become pregnant during the next month?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
13. Has the client received vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

I have received a copy of information about the vaccine(s) and the diseases they prevent. I have had a chance to ask questions and they were answered to my satisfaction. I understand the risks and benefits of the vaccine(s). I ask that the vaccine(s) be given to me or to the person for whom I am authorized to make this request. I also verify that all of the above information I supplied is correct to the best of my knowledge.

Susan Seffernick
 Signature of client/parent/guardian or person in loco parentis

11-24-2021
 Date

**ACKNOWLEDGEMENT OF
RECEIPT OF NOTICE OF PRIVACY PRACTICES**

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Print name of patient _____

Signature of patient or personal representative _____

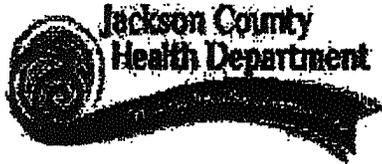
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 * Previously signed Other: _____

* Document program, if known: _____

Employee Signature _____ Date _____



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Private doses -	Vaccine type	Price
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

MCIR ID _____
 VFC - M-Cald, Un-Insured,
 Underinsured,
 American Indian, Alaska Native
 Private AVF
 Non-MSC Medicaid (please circle one)

*Last 4 of SS for part D clients only

Name of Client (Last, First, Middle) - please print Blalock, David		<input type="checkbox"/> Female <input type="checkbox"/> Male	Client Birth Date 12/8/82 Age _____ Month Day Year
Address 11219 Hamplers Ln Brooklyn	City Jackson	Zip Jackson	Telephone Home (571) 938-8722 Cell ()
Parent/Guardian name OR Maiden Name (Last, First, Middle) Jackson County Guardian	Today's Approx. Weight: _____ lbs.	Relationship to client: (please circle) Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Other <input type="checkbox"/>	
Does the client have Medicaid? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Medicaid # _____	Name of Client's Physician/Practice: _____	Race/Ethnicity: (please circle) Black <input type="checkbox"/> Hispanic <input type="checkbox"/> White <input type="checkbox"/> Other _____	
Does the client have other Insurance? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, does the insurance pay for immunizations? Yes <input type="checkbox"/> No <input type="checkbox"/>			

Screening Questions

These screening questions will help us determine which vaccines may be given today. If a question is not clear, leave it blank and the nurse will explain it.

Question	YES	NO	Don't Know
1. Is the client sick today, or have a fever?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the client have any allergies to medications, food, a vaccine component, or latex?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the client had a serious reaction to a vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the client had a health problem with lung, heart, kidney, or metabolic disease (e.g., diabetes), or a blood disorder? Is he/she on long-term aspirin therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Has the client been told by a health care provider that he/she has had wheezing or asthma in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Is the client a smoker?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. If the client is a baby, have you ever been told he or she has had intussusception?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Has the client, a sibling, or a parent had a seizure; has the client had brain or other nervous system problems? Has he/she ever had Guillain-Barre' syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Does the client have cancer, leukemia, HIV/AIDS, or any other immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. In the past 3 months, has the client taken medication that has weakened their immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments? Is he/she taking antiviral medications?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. In the past year, has the client received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Is the client pregnant or could she become pregnant during the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Has the client received vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Jackson County Health Department
 1715 Lansing Ave., Suite 221, Jackson, MI 49202
 Phone: (517) 223-2021

**ACKNOWLEDGEMENT OF
RECEIPT OF NOTICE OF PRIVACY PRACTICES**

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices.

Print name of patient _____

Signature of patient or personal representative _____

Guardian Services

Our practice will make a good faith effort to obtain a written acknowledgment of receipt of the Notice provided to the individual. If written acknowledgment is not obtained, our practice must document its good faith efforts to obtain such acknowledgment and record the reason why the acknowledgment was not obtained.

Please circle: Refused to Sign *Physically unable to sign
 *Previously signed Other _____

* Document program, if known: _____

Employee Signature _____ Date _____



IMMUNIZATION Client Registration Form Jackson County Health Dept. 1715 Lansing Ave., Suite 221 Jackson, MI 49202

Receipt#: _____ Check #: _____ Cash _____ VISA/MC Auth Code: _____ Discover _____ Adm. Fee - \$23.00 x _____ = \$ _____ Private doses - Vaccine type Price \$ \$ \$

MCIR ID _____ VFC - M-Caid, Un-Insured, Underinsured, American Indian, Alaska Native Private AVP Non-VFC Medicaid (please circle one)

*Last 4 of SS for part D clients only

Name of Client (Last, First, Middle) - please print: Vanepps Timothy; Address: 11219 Wampler's Ln Rd; City: Jackson; Zip: 49230; County: Jackson; Client Birth Date: 4/9/68; Telephone: (517) 938-8722; Relationship to client: Guardian; Race/Ethnicity: White; Physician/Practice: Center for Family Health - Columbus

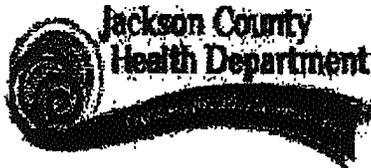
Screening Questions

- 1. Is the client sick today, or have a fever?
2. Does the client have any allergies to medications, food, a vaccine component, or latex?
3. Has the client had a serious reaction to a vaccine in the past?
4. Has the client had a health problem with lung, heart, kidney, or metabolic disease (e.g., diabetes), or a blood disorder?
5. Has the client been told by a health care provider that he/she has had wheezing or asthma in the past 12 months?
6. Is the client a smoker?
7. If the client is a baby, have you ever been told he or she has had intussusception?
8. Has the client, a sibling, or a parent had a seizure; has the client had brain or other nervous system problems?
9. Does the client have cancer, leukemia, HIV/AIDS, or any other immune system problem?
10. In the past 3 months, has the client taken medication that has weakened their immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments?
11. In the past year, has the client received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?
12. Is the client pregnant or could she become pregnant during the next month?
13. Has the client received vaccinations in the past 4 weeks?

I have received a copy of information about the vaccine(s) and the disease(s) they prevent. I have had a chance to ask questions and have been satisfied with the answers. I understand the risks and benefits of the vaccine(s) and I understand that I am authorized to make a decision about whether or not to have the vaccine(s). I have signed this form to indicate that I understand the risks and benefits of the vaccine(s) and I understand that I am authorized to make a decision about whether or not to have the vaccine(s).

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES. By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices. Print name of patient: _____ Signature of patient or personal representative: _____

Office Use Only. Our practice will make a good faith effort to obtain a written acknowledgment of receipt of the Notice provided to the individual. Please circle: Refused to Sign, Physically unable to sign, Previously signed, Other. Document progress, if known: _____ Employee Signature: _____ Date: _____



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Receipt #: _____ Check #: _____ Cash _____ VISA/MC Auth Code: _____ Discover _____ Adm. Fee - \$23.80 x _____ = \$ _____ Private doses - Vaccine type Price \$ _____ \$ _____ \$ _____

MCJR ID _____ VFC - M-Caid, Un-Insured, Underinsured, American Indian, Alaska Native Private AYP Non-VEG-Mathewitt (please circle one)

*Last 4 of SS for part D clients only

Name of Client (Last, First, Middle) - please print Parker Kirk Female Male Client Birth Date 10/30/55 Age _____ Address City Zip County Telephone Home (517) 938-8722 Cell () Parent/Guardian name OR Maiden Name (Last, First, Middle) Jackson County Guardian Today's Approx. Weight: lbs. Relationship to client: (please circle) Parent Guardian Other Does the client have Medicaid? Yes No Medicaid # _____ Name of Client's Physician/Practice: Race/Ethnicity: (please circle) American Indian Asian Black Hispanic White Other Does the client have other insurance? Yes No If Yes, does the insurance pay for immunizations? Yes No

Screening Questions The following questions will help us determine which vaccines may be given today. If a question is not clear, leave it blank and the nurse will explain.

- 1. Is the client sick today, or have a fever?
2. Does the client have any allergies to medications, food, a vaccine component, or latex?
3. Has the client had a serious reaction to a vaccine in the past?
4. Has the client had a health problem with lung, heart, kidney, or metabolic disease (e.g., diabetes), or a blood disorder? Is he/she on long-term aspirin therapy?
5. Has the client been told by a health care provider that he/she has had wheezing or asthma in the past 12 months?
6. Is the client a smoker?
7. If the client is a baby, have you ever been told he or she has had intussusception?
8. Has the client, a sibling, or a parent had a seizure; has the client had brain or other nervous system problems? Has he/she ever had Guillain-Barre syndrome?
9. Does the client have cancer, leukemia, HIV/AIDS, or any other immune system problem?
10. In the past 3 months, has the client taken medication that has weakened their immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments? Is he/she taking antiviral medications?
11. In the past year, has the client received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?
12. Is the client pregnant or could she become pregnant during the next month?
13. Has the client received vaccinations in the past 4 weeks?

I have read a copy of the information about the vaccines and the risks of not getting them. I have had a chance to ask questions and they were answered to my satisfaction. I understand the risks and benefits of the vaccines. I ask for the vaccine to be given to me on this date. I am authorized to make this request on behalf of the client. I understand that the vaccine is given to me on this date. I am authorized to make this request on behalf of the client. I understand that the vaccine is given to me on this date. I am authorized to make this request on behalf of the client.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices. Print name of patient Signature of patient or personal representative

Office Use Only Our practice will make a good faith effort to obtain a written acknowledgment of receipt of the Notice provided to the individual. If written acknowledgment is not obtained, our practice must document its good faith efforts to obtain such acknowledgment and record the reason why the acknowledgment was not obtained. Please circle: Refused to Sign *Physically unable to sign *Previously signed Other: Document program, if known: Employee Signature Date