MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see requiring document. Form is not valid without Requiring Document, Issuance Date, Local Form Number, and Edition Date.

REQUIRING DOCUMENT *(Title and Number)*	ISSUANCE DATE
LOCAL FORM TITLE NHCA IMMUNIZATION GENERAL CONSENT (North Severn)	

Name (last, first):	Sponsor's Full SSN or Patient's DOD ID:	Status: (Please circle all that apply) MIDN/ Active Duty/ Dependent/ Retired/ CIV Healthcare/ Occupational Health CIV	
Date:	DOB:	Records Maintained at:	Age:

Please answer the questions for the person being immunized. This form should be completed by the patient or legal guardian (if under age 18) By completing this form you acknowledge the following: Vaccine Information Sheets were available for review and that you understand the risks and benefits of the vaccine. You will wait in the clinic for 15 minutes to monitor for any signs of adverse reactions. A copy of vaccine record was provided on request. Pregnancy for women should be avoided for 30 days if a live vaccine is given.

1. Do you receive healthcare from the Johns Hopkins Family Health Plan? (If marked YES, please see TRICARE or health benefits manager before continuing)	NO	YES
2. At this time, are you moderately to severely ill?	NO	YES
3. Have you ever had a serious reaction to a previous immunization requiring medical care?	NO	YES
4. Have you ever had Guillain-Barre Syndrome (a severe paralytic illness, also called GBS)?	NO	YES
5. Do you or a family member have a history of seizures or other brain disorder?	NO	YES
6. Do you have any allergies to medications, foods, vaccine components, or latex? Please list if YES _____	NO	YES
7. Have you ever had a positive tuberculosis test (also known as PPD) or been treated for tuberculosis?	NO	YES
8. Are you currently pregnant or planning to become pregnant within the next 30 days?	N/A NO	YES
9. Do you have heart disease, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder or any other chronic health conditions?	NO	YES
10. Do you have a history of wheezing, reactive airway disease, asthma, or lung disease?	NO	YES
11. Do you have a weakened immune system because of HIV or another disease that affects the immune system, long term high dose steroid treatments, or cancer treatment with radiation or drugs?	NO	YES
12. Do you take any blood thinners (like aspirin or Coumadin) or have any bleeding problems?	NO	YES
13. Are you in close contact with severely immune-compromised individuals who must be in a protective environment (such as transplant recipients, cancer, HIV)?	NO	YES
14. Have you received had any blood transfusions, plasma transfusions, or immune globulin in past year?	NO	YES
15. Have you received any vaccines within the past 30 days? Please list if YES _____	NO	YES

Medication Reconciliation *(Please list all the medications you are currently taking):* ☐**Check if NONE**

Immunization Staff Use Only

Patient has no contraindications to the vaccines being given today. The VIS was available in the clinic for review. Vaccines documented in AHLTA.	YES	NO	SEE AHLTA FORVACCINE DOCUMENTATION IF AHLTA IS NOT WORKING THE VACCINES GIVEN ARE LISTED:
Patient's medications were reconciled prior to receiving the vaccine(s).	YES	NO	
All yes answers were reviewed with nurse, providers, or are deemed appropriate by standing orders/ contraindication list.	YES	NO	

Additional Comments

FOR EGG ALLERGY PATIENTS ONLY (Vaccine must be administered by RN or Provider). Patient reports egg allergy but is able to consume or has mild symptoms such as hives. Patient denies systemic symptoms. Patient would like to get flu vaccine in clinic. Patient is instructed to wait 15 minutes in clinic after vaccination. Patient instructed that this is a BLS clinic and all reactions will need to be transported via ambulance to closest ER. Patient/ Guardian Signature

VACCINATOR'S NAME:	VACCINATOR'S SIGNATURE	DATE

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)*

PLEASE SEE ABOVE FOR PATIENT IDENTIFICATION INFORMATION.

Office use if needed-

☐AHLTA ☐CHCS ☐MRRS ☐Medical Record

HOSPITAL OR MEDICAL FACILITY NHC Annapolis and Branch Health Clinics	STATUS As noted above
DEPARTMENT / SERVICE Immunizations	RECORDS MAINTAINED AT
SPONSOR'S NAME n/a	SSN As noted above
RELATIONSHIP TO SPONSOR n/a	

NHCANNA 6150/1 Exception to NAVMED 6000/5

Category _____

AUTHORITY: 10 USC 504, 505, 507, 532, 978, 1201, 1202, and 4346; and E.O. 9397.

PRINCIPAL PURPOSE: To obtain supplemental medical data for use in immunization general consent.

ROUTINE USES: Use and disclosure of your records outside of DoD may occur in accordance with 5 U.S.C. 552a(b) of the Privacy Act of 1974, as amended, which incorporates the DoD Blanket Routine Uses published at: http://dpclo.defense.gov/privacy/SORNs/blanket_routine_uses.html. Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), as implemented within DoD by DoD 6025.18-R. Permitted uses and disclosures of PHI include, but are not limited to: treatment, payment, and healthcare operations.

DISCLOSURE: Voluntary; however, failure to provide the information may result in delay of healthcare.