NEW MEXICO DEPARTMENT OF HEALTH ADULT VACCINE CONSENT FORM

This form is to be used for patients aged 19+ and older ONLY *Updated July 2026*

*Last Name: _____ *First Name: _____ MI: _____

*Date of Birth: _____ *Daytime Phone Number: _____ Email: _____
Month/Day/Year

*Mailing Address: _____ *City: _____ *State: NM * Zip: _____

Mother's Maiden Name:_____ Responsible Person: _____ Relationship: _____
First and Last Name

*Gender:	*Race:	*Ethnicity:
☐ Male ☐ Transgender	☐ American Indian/Alaska Native ☐ Black/African American	☐ Hispanic
☐ Female ☐ Unknown	☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other	☐ Not Hispanic

*INSURANCE INFORMATION – Fill in the appropriate category – REQUIRED

Turquoise Care/Medicaid: ☐ Blue Cross Blue Shield ☐ Presbyterian ☐ Molina ☐ United Healthcare

Policy/Member ID #: _____ Turquoise Care Medicaid #:_____ Group #: _____

Medicare Part B:

Subscriber ID #: _____ Responsible Party: _____ Policy Holder's Date of Birth: _____

☐ **No Insurance** ☐ **Private Insurance**

*MEDICAL SCREENING QUESTIONS – REQUIRED

For patients: The following questions will help us determine which vaccines you may be given today. If you answer 'yes' to any question, it does not necessarily mean you should not be vaccinated. It just means that additional questions must be asked. If a question is not clear, please ask your health care provider to explain it.	YES	NO	DON'T KNOW
1. Are you sick today?			
2. Do you have allergies to medications, food, a vaccine component, or latex? Please list:			
3. Have you ever had a serious reaction to a vaccine in the past?			
4. Do you have a long-term health problem with heart, lungs (including asthma), kidney, liver, nervous system, or metabolic disease (including diabetes), blood disorder, no spleen, a cochlear implant, or a spinal fluid leak? Are you on long-term aspirin therapy or salicylate medication?			
5. Do you have an immune system problem, such as cancer, leukemia, HIV/AIDS?			
6. Do you have a parent or sibling with an immune system problem?			
7. In the past 6 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs to treat rheumatoid arthritis, Chron's disease, or psoriasis, or have you had radiation treatments?			
8. Have you had a seizure or a brain or other nervous system problem, such as Guillain-Barre syndrome?			
9. Have you ever been diagnosed with myocarditis or pericarditis, or have you had Multisystem Inflammatory Syndrome (MIS-A or MIS-C) after an infection with the virus that causes COVID-19?			
10. In the past year, have you received immune (gamma) globulin, blood/blood products, or an antiviral drug?			
11. Are you pregnant, or is there a chance you could become pregnant during the next month?			
12. Have you received any vaccinations in the past 4 weeks?			
13. Have you ever felt dizzy or faint before, during, or after a shot?			
14. Are you anxious about getting a shot today?			
15. List of current medications:			

*CONSENT FOR VACCINATION

I have been given and have read or have had explained to me, the information in the Vaccine Information Statements(s) for the diseases and vaccine(s) checked below. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine requested and ask that the vaccine checked below be given to me or the person named for whom I am authorized to make this request. I request that payment of authorized benefits be made to the New Mexico Department of Health/Public Health Division/Immunization Program, for services furnished to me by that program. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable for related services. I specifically authorize the release of my Medicare or other insurance policy number to the NM Department of Health to allow the Department of Health to seek reimbursement for the vaccine and administrative costs. Unless I sign a statement signifying otherwise, I allow immunization information to be entered into the New Mexico Statewide Immunization Information System (NMSIIS) and be released to other medical providers to avoid unnecessary vaccination or to ascertain immunization status. The DOH Privacy Policies are available at https://nmhealth.org/hipaa.shtml and will be given to all patients when they receive and immunization.

***Signature (Client/Guardian):** _____ ***Date:** _____

DIRECT NMSIIS ENTRY OF VACCINES ADMINSTERED IS REQUIRED.
FOR NM DOH OUTREACH ONLY: Data must be entered into TransactRx within 30 days of the date of service.
This form was designed for NM DOH public health offices use only. NM DOH is not responsible for data entry from outside health entities.

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Patient Name: _____ Date of Birth: _____

FOR CLINIC USE ONLY						
Vaccine	Vaccine Admin. Date	Lot #	Site & Route	Vaccine Expiration Date	Funding Source (317/ASP)	Date of VIS
Covid-19 COMIRNATY® (Pfizer)	/ /			/ /		/ /
Covid-19 SPIKEVAX™ (Moderna)	/ /			/ /		/ /
Hepatitis A Adult HAVRIX® (GSK)	/ /			/ /		/ /
Hep A/B Adult TWINRIX® (GSK)	/ /			/ /		/ /
Hepatitis B Adult HEPLISAV-B™ (Dynavax)	/ /			/ /		/ /
Hepatitis B Adult ENGERIX-B® (GSK)	/ /			/ /		/ /
HPV GARDASIL®9 (Merck)	/ /			/ /		/ /
Influenza FLUARIX® TIV (GSK)	/ /			/ /		/ /
Influenza FLUZONE HIGH-DOSE® TIV (Sanofi Pasteur)	/ /			/ /		/ /
MMR Adult M-M-R®II (Merck)	/ /			/ /		/ /
MPOX JYNNEOS™ (Bavarian Nordic)	/ /			/ /		/ /
PCV20 PREVNAR 20™ (Pfizer)	/ /			/ /		/ /
RSV ABRYSVO™ (Pfizer)	/ /			/ /		/ /
Tdap Adult ADACEL® (Sanofi Pasteur)	/ /			/ /		/ /
Varicella VARIVAX® (Merck)	/ /			/ /		/ /
Zoster SHINGRIX® (GSK)	/ /			/ /		/ /
	/ /			/ /		/ /
	/ /			/ /		/ /

Vaccinator (print name):	Signature:	Date of Service:
Title of Vaccinator:	VFC Pin #:	Date VIS Given:

Entered *(circle one – cannot be both)*: BEHR or TransactRx	Non-DOH Supply: ☐ Yes ☐ No Mobile Team: ☐ Yes ☐ No	Notes:
Date Entered:		
Address/Location of Vaccines Given:		