ADULT VACCINE CONSENT & REGISTRATION FORM rev. 4/2015

These immunizations are being given under the direction and supervision of:
Emmanuel Christian Health Center Federal Tax I.D. 650184720
Vivian J. Woodard, M.D., Board Certified Internal Medicine, Graduate of Harvard Medical School
Certified Yellow Fever Vaccine Provider ME0053291
Office located at 918 Rolling Acres Rd., Suite 1, Lady Lake, FL 32159 (352) 259-1991

Last Name	First Name	M.I.	Date of Birth (M-D-Y)	Today's Date	Sex: M F

Local Mailing Address	City	State	Zip Code	Phone Number: ( )

Do you want us to send your primary care doctor a record of your vaccine(s)? Yes____ No____
If yes, give doctor's full name & Phone number:

Read the following and sign below next to the name(s) of the vaccine(s) you want to receive. Be sure to request, read, and understand the CDC Vaccine Information Statements for all vaccines you plan to take today. A Notice of Privacy Practices (HIPAA form) is also available for you to read and/or keep. Please ask all questions and discuss any concerns with a member of our staff prior to receiving your vaccine(s). Thank you and God bless you.

I consent to receive the vaccine(s) I have signed for below:

Yellow Fever (use separate registration form)	
Hepatitis A	
Hepatitis B	
Typhoid oral capsules (Vivotif)	
Typhoid shot (Typhim Vi)	
Tetanus diphtheria (Tenivac)	
Tetanus, diphtheria, and pertussis (Adacel)	
Meningitis conjugate MCV4 (Menactra)	
Meningitis polysaccharide MPSV4 (Menomune)	
Mumps, measles and rubella	
Polio shot (IPOL)	
Rabies	
Japanese encephalitis	
Varicella (chickenpox)	
Other vaccine (specify):_____	