Mission:
To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.

Florida HEALTH Monroe County

Ron DeSantis
Governor

Scott A. Rivkees, MD
State Surgeon General

Vision: To be the **Healthiest State** in the Nation

IMMUNIZATION REGISTRATION

Last Name: _____ **First Name:** _____
(Please Print) (Please Print)

Date of Birth: _____ Race: _____ **Sex:** _____

SS# _____-_____-_____ **Address:** _____

Lot/Apt#: _____ **City:**_____ **Zip Code:** _____

Phone: _____

Parent/Guardian Name: _____

INSURANCE INFORMATION – if insurance card not available to copy and information is known

NAME OF INSURANCE_____

Name of Policy Holder: _____
(Please Print)

Policy Holder's Employer: _____

Policy Number: _____ **Group Number:** _____

I have been given a copy of and read or have had explained to me the information contained in the Vaccine Information Statement. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and request that the vaccine indicated below be given to me or to the person named above for whom I am authorized to make this request."

Date VIS given: _____ **Are you currently or could you be pregnant? YES NO**
Allergies:_____

Patient/Parent/Guardian Signature:_____

Vaccine & VIS Update	Date Given	Brand Name	Mfg./Lot#	Route/Site	Signature/Title Of Provider
				IM/SQ RD LD	
				IM/SQ RD LD	
				IM/SQ RD LD	
				IM/SQ RD LD	

Date	_____	_____	_____
FL Shots	_____	_____	_____
HMS	_____	_____	_____
Billing	_____	_____	_____
Paid	_____	_____	_____

GENERAL CONSENT FOR CARE AND TREATMENT

Part I: Consent For Care and Treatment

I, _____(circle the applicable designation: Client/Representative), hereby authorize the _____ County health Department staff and its representative to render routine health care to myself or my child, _____ (insert "N/A", or "not applicable" if there is no child).

I understand that routine health care is confidential and voluntary and may involve provider office visits which include history taking, examinations, administration of medications, laboratory tests, and/or minor procedures. I understand that I may discontinue services at any time.

_____ _____
Signature of Client/Representative Date

_____ _____
Witness Date

Part II: Withdrawal of Consent For Care and Treatment

I,_____WITHDRAW THIS CONSENT, effective _____.
Client/Representative Signature Date

_____ _____
Witness (optional) Date

Name:_____
ID#:_____
DOB:_____