District Health Department #10
Healthy People, Healthy Communities

Immunization Clinic Form

Client Name: _____ DOB: _____

If Minor, Parent/Guardian Name: _____

Office Use Only
Date _____
PH# _____
○ Patient Pay ○ Private Ins. ○ VFC

Screening Checklist for Vaccines (Answer the following questions for yourself or for your child)	YES	NO	N/A
1. Is the client sick today?			
2. Does the client have allergies to: medications, a vaccine component, latex, eggs, Gentamicin, Cipro? Other ____			
3. Has the client ever had a severe reaction to a vaccine in the past including a component of a COVID 19 Vaccine?			
4. Has the client had a history of Keloid scars?			
5. Has the client had a health problem with lung, heart, kidney or metabolic disease, asthma, or a blood disorder?			
6. If the client is a baby, has he or she had intussusception?			
7. Has the client, sibling or parent had a seizure, brain, or other nervous system problem?			
8. Does the client have cancer, leukemia, HIV/AIDS, or any other immune system problems?			
9. In the past 3 months has the client taken medications that affect the immune system such as prednisone, other steroids or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatment?			
10. Does the child have a parent, brother or sister with an immune system problem?			
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 is there a chance she could become pregnant during the next month?			
13. Has the client received vaccinations in the past 4 weeks?			
14. Has the client received a dose of COVID 19 vaccine? If yes, which product? _____			
15. Has the client ever had a positive test for COVID 19?			
16. Has the client received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID 19?			
17. Does the client have dermal fillers?			
18. Is the client currently receiving hospice care?			
19. Does the client have a history of Myocarditis or Pericarditis?			
20. Has the client had a recent or known exposure to a communicable disease within the past 14 days?			

21. For Sliding Scale Calculations: Household Size _____ Household Income _____ Is this amount: Weekly ____ Monthly ____ Yearly

(Office Use Only) IMMUNIZATION NURSE SECTION

Vaccine Type	Lot #	Injection Site	Vaccine Type	Lot #	Injection Site
COVID 19 Moderna (6mths – 5 yr. old)			Hep B		
COVID 19 Moderna 0.5 ml Monovalent			HIB		
COVID 19 Moderna Bivalent Booster (18+)			HPV		
COVID 19 J&J			IPV		
COVID 19 Pfizer (6mth – 4 yr. old)			JYNNEOS		
COVID 19 Pfizer (5–11 yr. old)			Men B (Bexsero)		
COVID 19 Pfizer (12+) Monovalent			Menveo		
COVID 19 Pfizer Bivalent Booster (12+)			MMR		
COVID 19 Novavax			MMR/Varicella		
DT			Pneumococcal PCV13		
DTAP Infanrix			Pneumococcal PCV20		
DTAP IPV HIB Pentacel			Pneumococcal PPSV23		
DTAP/Hep B/IPV Pediarix			Rotavirus - Rotarix		
DTAP-IPV Kinrix			Rotavirus - Rotateq		
Flu .5 Sanofi MDV			TB Skin Test		
Flu .5 Sanofi 10 SYR			TD		
Flu Quad GSK 10 SYR			TDAP Boostrix		
Flu High Dose			Varicella		
Hep A			Zoster		
Hep A/Hep B Twinrix					

District Health Department #10
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Immunization Program
Clinical Services

Consent Immunization Services

Client Name: _____ **Date of Birth:** _____

Parent/Guardian Name: _____

I have read or have had explained to me the information regarding the vaccine I am to receive. I have received a copy of Vaccine Information Sheets (VIS) and/or Emergency Use Authorizations (EUA) about the disease(s) and the vaccine(s) which are to be administered today.

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 and ask that the vaccine be given to me, or the person named for whom I am authorized to make this request.

Client Signature: _____ **Date:**_____

Witness Signature _____ **Date:**_____

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REGISTRATION FORM

STAFF USE ONLY	Date	PH#	Location

Patient Information

Full Name *First, Middle, Last*			Preferred Phone		Receive TEXT messages? O Yes O No
Preferred Name		*Formerly Known As*	Email		
Date of Birth	*Mo Day Year*	Age	Preferred Appt Reminder	O Phone O Text O Email	
Gender	O Female O Male O Other _____		Health Insurance Type	O Medicaid O Medicare O Military O Commercial	
Race/Ethnicity		O Hispanic O Not Hispanic	Health Insurance Company Name		
Preferred Language	O English O Spanish	O Other – *name* _____	Policy Holder – *if NOT Self*	*Name* _____	*Birthdate [Month/Day/Year]*
Parent/ Guardian **Required if age 18/ under*	*Name*		Policy Holder *Relationship to Self*		
	Date of Birth *Mo Day Year*		Policy Number	*Write clearly; use Ø for zero*	
Social Security #	*Required for Medicare/Tricare*		Group Number		
Mailing Address			Emergency Contact	*Name* _____ *Phone* _____	
City		State	CARDS	ID: O Yes O No INSURANCE: O Yes O No	
County		ZIP	NOTES		

Signature/Review

Form completed by:

_____

Signature *Date*

District Health Department #10
Healthy People, Healthy Communities

Date	
PH#	
Location	

Declaration of Income & Consent

I affirm that all income, insurance, and payor information provided to District Health Department #10 is accurate and current. I further declare that I have read and understand all the content regarding consents below.

CONSENT FOR CARE

I consent to become a client or consent to my minor child to become a client of the District Health Department #10 (DHD#10). I understand that DHD#10 has a variety of programs for which I may be eligible, and that some of these programs have their own specific consent forms. I acknowledge that I am advised to remain in the clinic for fifteen minutes following treatment for observation of a possible adverse reaction to medications. I do not hold this agency nor its agents responsible in the event of an adverse medication reaction.

I understand that services offered by DHD#10, are confidential and that my information will not be disclosed without my consent, except when required by law. General information may be used for statistical purposes only. I understand that DHD#10 maintains an electronic record of the care and services I receive at DHD#10, as well as at any of its divisions, departments, or partner companies. My records from each DHD#10 program may be combined. DHD#10 needs this record to provide me with the best care possible and to comply with certain legal requirements.

DHD#10 complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. DHD#10 does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

DHD#10:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
- Qualified sign language interpreters or visual aids
- Provides free language services to people whose primary language is not English, such as
- Qualified interpreters
- Information written in other languages

I understand that my Electronic Medical Records can be accessed by all DHD#10 providers.

I further understand that DHD#10, from time to time, contracts with third-party health care providers to provide the most complete services to its clients. These health care providers may have access to my DHD#10 medical records, to the minimal extent necessary to provide services to me at DHD#10.

CONSENT TO RELEASE MEDICAL RECORDS AND INFORMATION TO INDIVIDUALS INVOLVED IN MY CARE OR PAYMENT FOR MY CARE

I authorize DHD#10 and its employees to release information from my financial or medical records to any person, organization, employer (if work-related injury), or review agency which is legally or contractually responsible or which DHD#10 reasonably thinks may be responsible for payment of my bills for my medical care. I further authorize DHD#10 to release information from my medical records to auditors and consultants who are advising DHD#10 on third party payor billing issues and/or assisting DHD#10 in preparing financial data and related documents. I understand that DHD#10 will maintain the confidentiality of my medical records, but I also understand that DHD#10 is not responsible for any breaches of confidentiality of my medical records caused by other parties. This permission includes information that may be related to drug or alcohol abuse, psychiatric care, HIV testing, AIDS (Acquired Immunodeficiency Syndrome), HIV infection or ARC (AIDS related complex) and includes social work/client communication and psychologist/client communications.

FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS

I authorize DHD#10 to bill all insurance payors and hereby assign to DHD#10 all my insurance and managed care benefits due to me for services rendered to me by DHD#10. I request that payment of the authorized benefits from those sources be made on my behalf to DHD#10 and authorize my insurance company and/or my managed care company to make payment directly to DHD#10. I understand that DHD#10 submits claims to insurance carriers as a courtesy to patients and that I am responsible for the balance owed unless DHD#10 has agreed with the payor not to balance bill. I agree to pay for all services rendered to me without regard to any benefit limitations imposed by any third-party payor, unless other arrangements are made in advance, to pay my account in full upon discharge from DHD#10; to pay any legal fees and interest at the legal rate, which result due to my not paying my balance. I understand that DHD#10 accepts no liability for failure to meet any pre-cost certification required by my insurance carrier, and I agree that I have, or will, properly execute such certification.

CONSENT TO OBTAIN INFORMATION/RECORDS

I authorize DHD#10 to obtain my information or records to or from hospital, health care providers, insurance companies, service agencies, auditors, or others involved in my care that may be pertinent to the delivery, coordination, and evaluation of my care. This includes all information about my status related to any medical condition(s), including HIV infection. I understand that such records and information include those that identify my name.

CONSENT RELATED TO PRIVACY NOTICE (ALSO KNOWN AS HIPAA)

This consent is required by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 to inform you of your rights for privacy with respect to your health care information.

I have had a chance to review the Practice Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change, and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

AFFIRMATION & SIGNATURE

I have read this consent form or have had it read to me. I have been able to ask questions and have been given answers to my questions. I also understand that a copy of this consent form can be given to me if I request a copy.

My signature is sign of consent.

Patient Signature	*Interviewer Signature*	*Interpreter Signature*
Date	*Date*	*Date*
Patient Name	*Interviewer Name*	*Interpreter Name*