School Name _____

Public Health
Prevent. Promote. Protect.

Cash _____

Check # _____ Amt. _____

Insurance _____

WAYNE COUNTY HEALTH DEPARTMENT

Nicholas Cascarelli, Ed.D. *Health Commissioner* **Eric A. Smith, MD** *Medical Director*

Patient Name: _____ Date of Birth: _____ Gender: □M □F

Race: □White □African-American □Asian □Multi-racial □Other Ethnicity: Hispanic/Latino: □ Yes □ No

Address: _____City_____State_____Zip_____

Primary Phone: (_____) _____-_____ Can we leave a message: Yes _____ No _____

Parent's Information

Mother: _____ DOB: _____ Phone_____

Address *(if different from Patient):* _____

Father: _____ DOB: _____ Phone_____

Address *(if different from Patient)* _____

Insurance Information:

In order to file insurance claims, we must have complete information below and a scanned copy of the insurance card.

Insurance Name _____ID#_____Group#_____

Effective Date of Insurance? _____

Insurance Subscriber _____ Date of Birth _____ Relationship _____

Screening Questions for all vaccines – Please answer questions as if the child is answering them. (Circle Yes or No for each question) Explain "Yes" answers below.			
Are you sick today?		**YES**	**NO**
Do you have any allergies or have you had any serious or life threatening reactions (anaphylaxis, difficulty breathing, etc.) to any foods, medications, or vaccines? (i.e.: eggs, gelatin, latex, etc.)		**YES**	**NO**
Do you have a history of seizures, Guillain-Barre Syndrome, or any other neurological conditions?		**YES**	**NO**
Do you have any medical conditions that weaken the immune system? (cancer, leukemia, AIDS, autoimmune disorders, etc.)		**YES**	**NO**
Do you take any medications or receive any treatments that affect your immune system? (i.e.: cortisone, prednisone, steroids, anti-cancer drugs, radiation treatments, etc.)		**YES**	**NO**
Have you received a transfusion of blood, plasma, or immune globulin in the last year?		**YES**	**NO**
Have you been treated for wheezing or diagnosed with asthma within the last 12 months?		**YES**	**NO**
Would you like a copy of the Wayne County Health Department Privacy Policy?		**YES**	**NO**
Are you pregnant? **NO** **YES** # of weeks(if "YES") _____	Are you breastfeeding?	**YES**	**NO**

PLEASE COMPLETE OTHER SIDE

INITIAL NEXT TO THE VACCINES YOU WANT YOUR CHILD TO RECIEVE

Parent Initial	Vaccine	Lot#	Exp. Date	Site
	DTaP or Tdap - based on age – *diphtheria, tetanus, pertussis (whooping cough)*			
	Hepatitis A			
	Hepatitis B			
	HIB – *Haemophilus influenza*			
	HPV9 – *Human Papilloma Virus*			
	IPV – *Inactivated Polio Virus*			
	Meningococcal-ACWY – *Meningococcal Meningitis*			
	MMR – *Measles, Mumps, Rubella*			
	Pneumococcal Pneumonia			
	Varicella – *Chicken Pox*			
	Meningitis B			
	Any vaccines recommended by the CDC immunization schedule for my child's age	Nurse Signature		

I hereby give my consent to the Wayne County Health Department to administer the vaccine(s) I have requested above. I understand the risks and benefits associated with the vaccine(s) being administered and have received, read and/or had explained to me the CDC's Vaccine Information Statement (VIS) on the vaccine(s) I have elected to receive. I have had the opportunity to ask questions that were answered to my satisfaction. As with all medical treatment, there is no guarantee that I will not experience an adverse reaction from the vaccine. I understand that the information contained on this form may be shared with the state immunization registries and will remain confidential and will not be released except as permitted or required by law. I acknowledge that I have received a copy of the Notice of Privacy Practices. Furthermore, I agree to remain near the vaccination location for approximately 10-15 minutes after administration for observation by the administering Healthcare Provider.

Patient/Child Printed Name: _____ Date of Birth: _____

SIGN HERE Parent Signature: _____ Date: _____

FOR HEALTH DEPARTMENT USE ONLY

_____ I have reviewed all immunization history to determine which vaccines are indicated for the client.

_____ I have reviewed the screening questionnaire and no contraindications have been found for the vaccines being administered.

Comments: _____

Nurse Signature: _____ Date/Time: _____