



# Children/Teen Immunizations

Registered: _____
Scanned: _____
EZ Imm Doc: _____
ICARE: _____
<b>Self-Pay</b>  <b>Medicaid</b>  <b>Private INS</b>

Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_ Male Female Other

Street Address \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_ PID/MRN \_\_\_\_\_

Race \_\_\_\_\_ Ethnicity: Hispanic or Latino NonHispanic or Latino Other

Select	Vaccine	Lot#	Site	Nurse Date/Time
	DTaP			
	Hep A			
	Hep B			
	Hib			
	HPV			
	Kinrix (DTaP + IPV)			
	Meningococcal			
	Meningococcal B			
	MMR II			
	Pediarix (DTap + IPV+HepB)			
	Pneumococcal 13			
	Polio (IPV)			
	Proquad (MMR V)			
	Rotavirus			
	TD (special order only)			
	Tdap			
	Varicella			
	Influenza			
	<b>COVID:</b>			
	Moderna Biv 6mo-4yrs 1 2			
	Moderna Biv 5yrs 1 2			
	Moderna Biv 6-17yrs 1 B*			
	Pfizer Biv 6mo-4yr 1 2 3			
	Pfizer Biv 5yrs 1			
	Pfizer Biv 6-17yrs 1 B*			
	Novavax 12 -17 1 2			

\*For immunocompromised individuals only

**MEDICAID: RECIPIENT ID#** \_\_\_\_\_

NO INSURANCE/UNDERINSURED/ AMERICAN INDIAN/ALASKIAN NATIVE: **VFC** (TITLE 19) **CHIP** (TITLE 21)

**PRIVATE INSURANCE:** \_\_\_\_\_

PRIMARY INSURED NAME: \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ **PRIVATE**

MEMBER ID#: \_\_\_\_\_

*I believe I understand the benefits, the risks of the vaccine(s) and ask the vaccine(s) stated above be given to me or the person above who I am authorized to make this request.*

*I understand that the HD is authorized to use the information gained during treatment to bill me or any other potential sources of reimbursement, such as government programs in which I am enrolled or qualified for services. Also, by signing I acknowledge that I am responsible for any remaining balance or co-pays that the provided insurance does not cover.*

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

\_\_\_\_\_  
Printed Name if not the patient                      Relationship to the patient

**I would like to speak to someone regarding financial assistance for immunization costs**

For parents/guardians: The following questions will help us determine which vaccines your child may be given today. If you answer “yes” to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

<b>Screening Questions</b>	<b>Yes</b>	<b>No</b>	<b>Unsure</b>
Is the child sick today?			
Does the child have allergies to medications, food, a vaccine component, or latex? Describe:			
Has the child had a serious reaction to a vaccine in the past? Describe:			
Does the child have a long-term health problem with lung, heart, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Is he/she on long-term aspirin therapy? Describe:			
If the child to be vaccinated is 2 through 4 years of age, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?			
If your child is a baby, have you ever been told he or she has had intussusception?			
Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?			
Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem? Describe:			
Does the child have a parent, brother, or sister with an immune system problem?			
In the past 3 months, has the child 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 treatments? Describe:			
In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?			
Is the child/teen pregnant or is there a chance she could become pregnant during the next month?			
Has the child received vaccinations in the past 4 weeks?			
Has the child ever had Guillain-Barre Syndrome?			

- I would like information on the WIC nutritional supplement program, or other services available at the Health Department**