Central Utah Public Health Department Registration Form

Last Name: First Name: Female Male Date of Birth Age

Mailing Address: City State Zip Phone#

Race: Please circle one White Asian African American Alaskan Native Pacific Islander Native American Other

Hispanic Yes No

For Office Use Only

VFC: Medicaid # _____ No Insurance Native American/Native Alaskan Chip

Adult Medicaid # _____ Medicare # _____ Medicare HMO Name_____

Insurance: PEHP Select Tall Tree DMBA PCN EMI BCBS Humana PPO United TriCare Cigna Aetna

Insurance # _____ Group _____

Name of Insured _____ Relationship _____

Email Address _____ Insured Date of Birth _____

Self Pay Amount: _____ Cash Check# _____ Credit Card Receipt #_____

CLERK'S INITIAL _____

Please answer the following questions:

Is the person to be vaccinated sick today?	**Yes**	**No**
Does the person to be vaccinated have an allergy to eggs, gelatin, thimerosal or other vaccine component?	**Yes**	**No**
Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	**Yes**	**No**
Has the person to be vaccinated ever had Guillian-Barre Syndrome?	**Yes**	**No**

Screener's Initials _____

I certify that the information I have provided is true and accurate. I have been given a copy and have read, or have had explained to me, the information contained in the Vaccine Information Statement about the disease. I have had a chance to ask questions, where were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) indicated be given to the person named above for who I am authorized to make the request.

I agree that the information form may be shared with schools, daycare centers, health care providers and others when deemed medically necessary.

I hereby release the Central Utah Public Health Department and their employees from all claims arising from such immunizations.

I authorize Medicaid or insurance benefits to be paid to the Central Utah Public Health Department or its authorized agent and for CUPHD or its authorized agent to release information to Medicaid or insurance companies as necessary to claims, Medicare & Insurance. **I understand that I may be liable for all or a portion of the bill.**

Notice of Privacy Practices and Acknowledgement of Receipt Effective April 14, 2003

The notice of Privacy Practices tells you how CUPHD may use or disclose information about you. Not all situations will be described. CUPHD is required to inform you of our privacy practices for the information we collect and keep about you. **I have been given a copy of CUPHDS's Notice of Privacy Practices and have had a chance to ask questions about how information can be used.**

X_____ Date _____

Signature of patient or parent/guardian

FOR OFFICE USE ONLY:

Vaccine	Lot #	Dose	Site	Vaccinator Signature
VFC Flu 6-35 mo 90685		**.25 mL**	**LVL RVL**	
VFC Flu >3 yrs - <19 yrs 90686		**.5 mL**	**LD RD**	
Flu > 6 mo 90686		**.5 mL**	**LVL RVL**	
FluMist 90672		**.5 mL**	**Nasal**	
FluBlok 50-65 90673		**.5 mL**	**LD RD**	
Flu- High Dose 90662		**.5 mL**	**LD RD**	

TIME IN _____ **TIME OUT** _____