

CENTRAL UTAH PUBLIC HEALTH DEPARTMENT-IMMUNIZATION FORM

BIRTH DATE _____ / _____ / _____

Visit Date _____ / _____ / _____

Patient's Name _____

Patients Mother's Maiden Name: _____

Age _____ Race _____ Sex M F Phone Number (_____) _____ - _____

Parent or Guardian _____

Mailing Address _____ City, State, Zip _____

Name of Insurance _____

Name of Insured _____ Relation to Insured: _____

Policy #: _____ Group # _____

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

The notice of Privacy Practices tell 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 CUPHD's Notice of Privacy Practices and have had a chance to ask questions about how information can be used.**
INITIALS: _____

RISK OF WOMEN OF CHILD BEARING AGE RECEIVING RUBELLA OR VARICELLA VACCINE:

I understand the risk to an unborn in the event that I should become pregnant within one month of receiving rubella or varicella vaccine. I assume personal responsibility to prevent becoming pregnant for one month following rubella or varicella vaccine.
Initials: _____

I have been given a copy and have read, or have had explained to me, the information contained in the Vaccine Information Statement(s). I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) indicated on this page be given to me or to the person for who I am authorized to make the request. I agree that the information on this form may be shared with schools, daycare centers, health care providers and others to verify immunization status, for public health studies, or when medically necessary. I hereby release the CUPHD to bill Medicaid, Medicare & Insurance. **I understand if my insurance provider fails to cover the cost of the immunization, I will be responsible for these services.**

Signature _____ Date _____ Relationship to Patient _____

*****FOR OFFICE USE ONLY*****

North Sanpete	South Sanpete
Juab	Wayne
Piute	Sevier
East Millard	West Millard

PAYMENT SECTION

Total Charge: _____
 Amount Received: _____
 Total Owing: _____
 Receipt #: _____

VFC Eligibility: (circle one)
 Medicaid Native American Native Alaskan
 Uninsured Underinsured CHIP

- | | | |
|----------|-----------|-------------|
| CASH | CHECK | CREDIT CARD |
| MEDICAID | MEDICARE | PCN |
| CHIP | INSURANCE | CONTRACT |

Allergies: _____

Comments: _____

Nurse/Provider: _____

Employee Signature:

BILL ORGANIZATION: _____

ORG. ADDRESS: _____

CHECK IN _____ USIIS: _____

PAYMENT: _____ COMPUTER: _____

Screening Checklist for Contraindications to Vaccines for Children and Teens

PATIENT NAME _____

DATE OF BIRTH _____ / _____ / _____
month / day / year

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.

	yes	no	don't know
1. Is the child sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the child have allergies to medications, food, a vaccine component, or latex?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the child had a serious reaction to a vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. If your child is a baby, have you ever been told he or she has had intussusception?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Does the child have a parent, brother, or sister with an immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Has the child received vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FORM COMPLETED BY _____ DATE _____

FORM REVIEWED BY _____ DATE _____

Did you bring your immunization record card with you? yes no

It is important to have a personal record of your child's vaccinations. If you don't have one, ask the child's healthcare provider to give you one with all your child's vaccinations on it. Keep it in a safe place and bring it with you every time you seek medical care for your child. Your child will need this document to enter day care or school, for employment, or for international travel.

