Patient Information	
First name:	Race: ◯ Multi-racial ◯ American Indian
Middle:	◯ White ◯ African American ◯ Nat. Hawaiian, Pac Isl
Last:	◯ Asian ◯ Other
Nickname:	
Other last names:	Ethnicity: ◯ Hispanic ◯ Unknown
Birthdate:	◯ Non- Hispanic
Age:	Language:
Gender:	Health Care plan name:
Mother's maiden name:	ID #:
Allergies:	Photo copy of card required

Primary Address	
Address 1:	
City:	State:
Zip code:	County:
Home phone:	
Email:	School:
Country:	Physician:

Family & Contact	
Parent/Guardian 1 First:	Parent/Guardian 2 First:
Middle:	Middle:
Last:	Last:
Phone: ◯ Cell ◯ Home ◯ Work	Phone: ◯ Cell ◯ Home ◯ Work
Point of Contact: ◯ Parent/Guardian 1 ◯ Parent/Guardian 2 ◯ Other_____	

Other Information	
Birth Country:	Birth State:

I have read or had explained to me the information in the "Vaccine Information Statement(s)"or the "Important Information Statement(s)" for the disease(s) and vaccine(s) to be prevented and received today. I have had the chance to ask questions and fully understand the benefits and risks of the vaccine(s) to be administered today. I request that the necessary vaccines be given to either me or the bersom named above.

_____ _____

Parent/Guardian Signature Date

FOR CLINIC USE ONLY

Clinic: Dearborn County Health Department 165 Mary St. Lawrenceburg, IN 47025-1910	Date Vaccinated: Date VIS provided to Parent/guardian/patient:

Vaccine	Dose	Manf. & Lot #	Route/Site	Date of VIS
DT DTaP			IM	5/17/2007 8/24/2018
Td Tdap			IM	4/11/2017 2/24/2015
Hep B			IM	11/5/2015 7/20/2016 10/12/2018
IPV			SQ	11/5/2015 7/20/2016
MMR			SQ	2/12/2018
HIB			IM	4/2/2015 11/5/2015
Varicella			SQ	2/12/2018
PCV-13			IM	11/5/2015
MCV4 Menveo Menactra			IM	8/24/2018
Men B			IM	8/9/2016
HPV 9			IM	12/2/2016
Hep A			IM	7/20/2016
MMR/Varicella			SQ	2/12/2018
DTaP/IPV (Kinrix)			IM	5/17/07 7/20/16 11/5/2015
DTaP/Hep B/IPV (Pediarix)			IM	5/17/07 7/20/16 7/20/16 11/5/15
DTaP/HIB/IPV (Pentacel)			IM	5/17/07 7/20/16 4/2/15 11/5/15
Rotavirus RV5 RV1			PO	2/23/2018
Flu 0.25 0.5			IM	8/7/2015

Signature and title of vaccine administrator

Patient Eligibility Screening Record

Instructions: 1. A record of all children 18 years of age or younger who receive immunizations must be kept in the health care provider's office.

2. Complete all information in section A at each screening visit.

3. Log the screening date and **initial** the appropriate eligibility category below for each vaccination.

A. Patient Information

Patient's Name _____

Patient's Date of Birth _____ (month/day/year)

B. Initial Patient Eligibility Screening

Screening Date _____ (month/day/year)

_____ Medicaid: A child, 0 thru 18 years of age, who has any form of Medicaid insurance.

_____ American Indian/Alaskan Native: A child, 0 thru 18 years of age, who identifies as an American Indian or Alaskan Native, regardless of insurance.

_____ No Health Insurance: A child, 0 thru 18 years of age, who does not have health insurance.

_____Limited Health Insurance: A child, 0 thru 18 years of age, who has private health insurance, but the coverage does not include vaccines, only covers selected vaccines, or whose insurance caps at a certain amount – making them eligible once the cap is reached.

_____**Health insurance that provides coverage for vaccines: Although, we cannot provide vaccines at these clinics to children whose private health insurance covers the vaccines, we now have contracts in place to bill the following insurance companies. Please let us know if you have any of the following insurance coverage for vaccines:**

Anthem Cigna Encore Humana Sagamore UnitedHealthCare

C. VFC eligibility screening must take place with each immunization visit to ensure the child's eligibility status has not changed.

LIABILITY RELEASE

I hereby release the Dearborn County Health Department, its agents and employees, from all liability resulting from vaccination and immunizations of my child/children/or myself including, but not limited to, local inflammation and allergic reactions.

_____

Signature-Parent or Legal Guardian

_____

Print Name-Parent or Legal Guardian

_____

_____

Mailing Address

Patient name: _____ Date of birth: ____/____/____ (mo.) (day) (yr.)

Screening Checklist for Contraindications to Vaccines for Children and Teens

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?	☐	☐	☐
2. Does the child have allergies to medications, food, a vaccine component, or latex?	☐	☐	☐
3. Has the child had a serious reaction to a vaccine in the past?	☐	☐	☐
4. Has the child had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy?	☐	☐	☐
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?	☐	☐	☐
6. If your child is a baby, have you ever been told he or she has had intussusception?	☐	☐	☐
7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	☐	☐	☐
8. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
9. In the past 3 months, has the child taken medications that weaken their immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments?	☐	☐	☐
10. 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?	☐	☐	☐
11. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	☐	☐	☐
12. Has the child received vaccinations in the past 4 weeks?	☐	☐	☐

Form completed by: _____ Date: _____

Form reviewed by: _____ Date: _____

Did you bring your child's 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.

Technical content reviewed by the Centers for Disease Control and Prevention

IMMUNIZATION ACTION COALITION Saint Paul, Minnesota • 651-647-9009 • www.immunize.org • www.vaccineinformation.org

www.immunize.org/catg.d/p4060.pdf • Item #P4060 (1/15)