CLIENT INFO. **SIDNEY-SHELBY COUNTY HEALTH DEPARTMENT**

Name: Last	First	Middle Initial	Birth Date	Age

Mailing Address	City	County	State	Zip

Telephone	Alternative Phone	Race **(circle one)** Asian Black Hispanic White American Indian Alaskan Native Multi-Race Other	Sex: M F

Child's Doctor	Date of last exam	School/Daycare	Parent/Guardian's name	Parent/Guardian's Birth Date

1. This client: **(circle one)** 1**)** Is covered by Medicaid **2)** Has health insurance that covers immunizations for this visit **3)** Has health insurance that does not cover immunizations or has limited coverage **4)** Does not have health insurance
2. Will you be returning to the Health Department for the next immunizations? . . . . . YES NO
3. If client is a child, do you have legal custody or written permission from parent/guardian for treatment? . YES NO
   If NO, talk to Health Department staff immediately.
4. Has this client had vaccines elsewhere in the past 6 months? . . . . . YES NO
5. Is this client ill, have any ongoing medical problems, or history of thrombocytopenia? . . . . . YES NO
   If YES, list them_____
6. Has this client taken any medications this past week? . . . . . YES NO
7. Has client had a reaction to latex, neomycin, streptomycin, eggs, yeast, gelatin or past immunizations?. . YES NO
8. Has this client had Immune Globulin or a blood transfusion in the last three months? . . . . . YES NO
9. Is anyone in this client's home taking medications for cancer or have any disease which reduces their immune function (Hodgkin's Disease, etc.)? . . . . . YES NO
10. Has this client, parents, or sibling ever had a convulsion, seizure, or history of Gullain-Barre Syndrome?.. YES NO
11. Are you pregnant, think you are pregnant, or might get pregnant in the next three months? . . . . . YES NO
12. Has this client ever had the chickenpox disease? Date of chickenpox disease _____ YES NO
13. This client would like referral to: **(please circle)** **1)** WIC **2)** Help Me Grow **3)** Well Child Clinic

I have received a copy of appropriate information about the disease(s) and vaccine(s) indicated below. I have read or have had explained to me this information. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and ask that the vaccine(s) indicated on this record be given to me or to the person above for whom I am authorized to make this request. ***I have been advised to wait 15 minutes after the injection to monitor for signs and systems of an allergic reaction.*** *I give permission to the Sidney-Shelby County Health Department to release/receive the immunization records of the above named child to any doctor, school and/or agency when requested. I also acknowledge receipt of the Shelby County Health Department's Notice of Health Information Privacy Practices.*

Signature of person to receive vaccine or person authorized to make the request (parent or guardian):

X _____ Date: _____

Relationship to Client:

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VIS Dates: DTAP: 5/07 HIB:12/98 Hep A: 3/06 Hep B: 7/07 HPV: 5/11 IPV: 1/00 Mening: 1/08 MMR: 3/08 MMRV: 5/10 Multi Baby: 9/08 PCV-13: 4/10 PPSV23: 10/09 Rabies: 10/09 RotaV: 12/10 Tdap/Td: 11/08 Typhoid: 5/04 Chickenpox: 3/08 Yellow Fever: 03/11 FLU: 7/11

Vaccine	Date Given	Manufacturer	Lot Number	Site	Route	Administered By
_____				LA RA LT RT	PO ID IM SQ	
_____				LA RA LT RT	PO ID IM SQ	
_____				LA RA LT RT	PO ID IM SQ	
_____				LA RA LT RT	PO ID IM SQ	
_____				LA RA LT RT	PO ID IM SQ	

- ❑ HIPAA notice provided
- ❑ VIS provided
- ❑ Cash
- ❑ Check

TOTAL CHARGE: $ _____ Initials _____ Receipt # _____ Medicaid # _____