209 W. 2nd Ave
Hutchinson, KS 67501
P: 620-694-2900
F: 620-694-2905

Pediatric Registration Form

Name: _____ **Sex:** Male ☐ Female ☐

D.O.B. _____ **Email:** _____

Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed ☐Partnered

Address: _____

County: _____ **Phone Number:** _____

Preferred Language: _____

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic

Race: ☐ Asian ☐ Am. Indian/Alaska Native ☐ Black/African American

☐ Native Hawaiian/Pacific Islander ☐ White

Other: _____

If under 18 years of age, please fill out all Responsible Party Information

Responsible Party: _____ **D.O. B:** _____

Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed ☐Partnered

Social Security Number of Responsible Party: _____ **Sex:** Male ☐ Female ☐

If NO Insurance: (choose an option)

☐ **Self-Pay**

☐ **Sliding-Fee-Scale:**

-Number in Household _____

-Income Amount: _____

(Circle one) Annually Bi-weekly Weekly Quarterly Monthly

If Insurance: (copy of card & sub DOB or fill in)

Insurance Name: _____

Policy Subscriber: _____

Subscriber D.O.B.: _____

Policy Number: _____

Pediatric Vaccine Screening Questionnaire

____ Yes ____ No Is the child to be vaccinated currently sick or experiencing a high fever?
____ Yes ____ No Does the child have allergies to medications, food, latex, or a vaccine component?
If yes: _____
____ Yes ____ No Has the child had a serious reaction to a vaccine in the past? If yes: _____
____ Yes ____ No Has the child had a health problem with lungs, heart, lung, kidneys, or metabolic disease (e.g., diabetes), asthma, or a blood disorder? Is he/she on a long-term aspirin therapy?
____ Yes ____ No Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problems?
____ Yes ____ No If the child to be vaccinated is between the ages of 2 and 4 years, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?
____ Yes ____ No If your child is a baby, have you ever been told he or she had intussusception?
____ Yes ____ No Has the child, sibling, or a parent had a seizure: has the child had brain or other nervous system problems?
____ Yes ____ No Does the child to be vaccinated have close, regular contact with someone with a weakened immune system?
____ Yes ____ No In the past 3 months, has the child taken medication that weaken their immune system, such as cortisone, prednisone, other steroids, antiviral medications, anticancer drugs, or had radiation treatments?
____ Yes ____ No Has the child to be vaccinated received blood, plasma, or immune globulin in the past 12 months?
____ Yes ____ No Is the child/teen pregnant or is there a chance she could become pregnant during the next month?
____ Yes ____ No Has the child received vaccinations in the past 4 weeks?

I acknowledge that I have been offered a copy of the Reno County Health Department's Notice of Privacy Practices.

I authorize the release of the medical or billing information necessary to process claims, for insurance providers including Medicare. I have been informed that if I provide a copy of my Health Insurance or Medicare card, a claim for service will be submitted to my insurance provider. If an insurance claim is denied, services will be billed to me at full charge unless the Income Documentation section has been completed and qualifies me for a reduced rate.

NOTE: According to Kansas Statue 65-531

Information and records which pertain to the immunization's status of persons against childhood diseases as required by K,S,A, 65-508 and 65-519 may be disclosed and exchanged without a parent or guardian's written release authorizing such disclosure to those who need such information to assure compliance with state statues or to achieve age appropriate immunization status for children. See State Statute 65-531 for complete description.

I consent to the inclusion of immunization data in the Kansas Immunization Registry.

_____ _____
Client/Parent/Legal Guardian signature Date

FOR NURSE USE ONLY- IMMUNIZATIONS GIVEN: