CHILD/ADOLESCENT IMMUNIZATION FORM

IMMUNIZATIONS NEEDED:

___ TDAP ___ MMR ___VZV ___PEDIARIX ___ HEP B ___HEP A ___ MCV4 ___GARDISIL (HPV)
___ HIB ___ PREVNAR ___ ROTATEQ ___ DTAP ___ OTHER_____

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	NA
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 or she on long-term aspirin therapy?	☐	☐	☐	☐
5. 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?	☐	☐	☐	☐
6. If your child is a baby, have you ever been told he or she has had intussusception? (a life-threatening illness that occurs when a portion of the intestine folds like a telescope, with one segment slipping inside another.)	☐	☐	☐	☐
7. Has the child, a sibling, or a parent had a seizure, or 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, anticancer drugs, or radiation treatment?	☐	☐	☐	☐
10. Has the child received vaccinations in the past 4 weeks?	☐	☐	☐	☐
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?	☐	☐	☐	☐
12. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	☐	☐	☐	☐

PONDERA COUNTY HEALTH DEPARTMENT

imMTrax ☐

PATIENT REGISTRATION FORM

RXNT ☐

Patient Name: _____ DOB: ____ /____ /____ Gender: M / F / Other

Parent/Guardian (18 & Younger ONLY): _____

Billing Address: _____ City: _____ State: _____ Zip: _____

Phone-Home: _____ Cell: _____

Does the patient have, or is the patient covered by health insurance? YES or NO (Circle One)

If a copy of the card is provided only areas in **BOLD need to be filled out, otherwise complete entirely**

Insurance Company: _____ Policy Number: _____ Group: _____

Policy Holder: _____ Policy Holder Date of Birth: ____ /____ /____

What is the relationship with Policy Holder? Spouse Child Self Other: _____ (Circle One)

Policy Holder Address: _____ (if same as above write 'same')

SECONDARY INSURANCE COMPANY NAME: _____

Policy Holder: _____ *Policy Number:* _____ *Group:* _____

STATE-PROVIDED VACCINE FOR CHILDREN (VFC) IS AVAILABLE, AT NO COST, TO THOSE WHO APPLY

READ BELOW TO DETERMINE IF YOUR CHILD IS VFC OR PRIVATE: Please **CIRCLE the appropriate statement that applies to your child.**

- VFC (Medicaid or Healthy Montana Kids Plus)
- VFC (Has private insurance but has a high deductible or the company doesn't cover vaccines)
- VFC (American Indian or Alaska Native)
- VFC (Has NO Health Insurance)
- PRIVATE (Has private insurance that pays for vaccines, some examples are BCBS, Pacific Source, EBMS)
- PRIVATE (BCBA Chips or Healthy Montana Kids)

CONSENT TO TREAT: I authorize PCHD to administer treatment as deemed necessary for the care of the patient named above. I certify that I am the parent or legal guardian of the patient. I also certify that no guarantee or assurance has been made as to the results that may be obtained from the treatment.

ASSIGNMENT OF BENEFITS: All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. The patient/parent/responsible party is responsible for any unpaid balances. Co-Payments will be made at the time of service. I request that payment of authorized Medicare, Medicaid, or other insurance company benefits be made to Pondera County Health Department (PCHD) for any services furnished to me by the PCHD. Regulations pertaining to Medicare and Medicaid assignment of both benefits apply. My signature indicates all information provided is true and correct.

CONSENT FOR INCLUSION IN MONTANA'S STATEWIDE IMMUNIZATION INFORMATION SYSTEM (IIS): I AUTHORIZE Pondera County Health Department to collect and enter my or my child's immunization records into the Department of Public Health and Human Services Immunization Information System (IIS). The IIS is a confidential, computer system that contains immunization records. I understand that information in the registry may be released to a public health agency as well as my or my child's health care providers to assist in my or my child's medical care and treatment. In addition, information may be released to child care facilities and schools in which my child is enrolled to comply with state immunization requirements. I understand that I can revoke this authorization and have my or my child's record removed at any time by contacting my local health department.

MUST SIGN:_____ **DATE:** ____ /____ /____

OFFICE USE ONLY:

VACCINE 1:	VACCINE 2:	VACCINE 3:	VACCINE 4:
LOT#/EXP:	LOT#/EXP:	LOT#/EXP:	LOT#EXP:
SITE:	SITE:	SITE:	SITE:
VIS:	VIS:	VIS:	VIS:
STAFF INITIALS:	STAFF INITIALS:	STAFF INITIALS:	STAFF INITIALS:
STOCK: VFC or PRIVATE	STOCK: VFC or PRIVATE	STOCK: VFC or PRIVATE	STOCK: VFC or PRIVATE
DATE:	DATE:	DATE:	DATE: