



Boise Office 707 N. Armstrong Place, Boise, ID 83704

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To improve the health of our communities by identifying sustainable solutions to community health issues, developing partnerships for implementation of strategies, and demonstrating our success through measurement of outcomes.

CLIENT INFORMATION (PLEASE PRINT)

Last Name: _____ First Name: _____ Middle: _____

Date of Birth: _____ Age: _____ Gender: M or F

Mailing Address: _____ Phone Number: _____

City: _____ State: _____ Zip: _____

Email address: _____ (for reminder recall only)

Parent or Guardian name: _____
(when applicable)

Circle all that apply *Ages 0-18 yrs only*

Medicaid / No Insurance / Insurance / American Indian / Alaskan Native

FINANCIAL POLICY: Effective July 1, 2009

INSURANCE: You will be responsible for balance owing on any vaccine and administration of vaccines that the insurance does not cover. **CDHD will bill primary insurance only!**

MEDICAID: Please present your Medicaid card at check-in. Non-covered services will be your responsibility.

No childhood immunizations will be denied due to inability to pay. Please ask for information at check-in.

Primary Insurance Patient's relationship to insured: Self Spouse Child

Insurance Company: _____ Name of Primary Insured: _____

Insured Date of Birth: _____ Insured Phone: _____

ID#: _____ Group #: _____

Insured's address if different from above: _____

Medicaid Information

Name (as printed on card): _____ Medicaid# _____

FOR OFFICE USE ONLY

Payment Category:

Staff initials: _____

Cash

Credit/Debit Card

Check Number _____

3rd Party Billing Company Name _____

Slide

Please complete other side



Patient Name _____ Date of birth: _____ / _____ / _____

**SCREENING QUESTIONNAIRE FOR
 INTRANASAL INFLUENZA VACCINATION**

For adult patients as well as parents of children to be vaccinated.

The following questions will help you determine if there is any reason we should not give you or your child Intranasal influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or 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.

How old are you? _____ (you must be between 2 yrs & 49 yrs old)

YES

NO

Is the person to be vaccinated today moderately or severely ill?

Does the person to be vaccinated have an allergy to chicken eggs or to a component of the influenza vaccine?

Has the person to be vaccinated ever had a serious reaction to intranasal influenza vaccine (FluMist®) in the past?

Does the person to be vaccinated have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorders?

Does the person to be vaccinated have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long-term treatment with drugs such as steroids, or cancer treatment with x-rays or drugs?

Is the person to be vaccinated receiving aspirin therapy or aspirin-containing therapy?

Is the person to be vaccinated pregnant or could she become pregnant within the next month?

Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in a protective environment (such as in a hospital room with reverse air flow)?

Has the person to be vaccinated received any other vaccinations in the past 4 weeks?

Has the person to be vaccinated ever had Guillain-Barré syndrome?

I have read the above information about FluMist and have truthfully answered all of the questions on this form. I have also received a copy of the Vaccine Information Statement for FluMist. I have had a chance to ask questions and fully understand the benefits and risks of vaccination with FluMist. My signature below indicates my permission for FluMist to be given to me.

Signature of person receiving vaccine or the person authorized to make the request:

SIGNATURE X _____ **DATE** _____

Date _____

Nurse Signature _____

Return Date _____

(FOR NURSES USE ONLY)