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Mountain Home Office 520 E. 8th N. Street, Mt. Home ID 83647

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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.

PATIENT INFORMATION (PLEASE PRINT)

Last Name: _____ First Name: _____ Middle: _____

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

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

OPTIONAL

Ethnicity Hispanic / Not Hispanic / Unknown **Race** White / American Indian / Black / Alaskan Native / Asian / Hawaiian—Pac Islander / Other

Home Phone: _____ Work: _____ Message: _____

Parent or Guardian _____ Mother's Maiden Name _____

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

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

At birth were you a: Single / Twin / Triplet / Other **Is the patient on the WIC program?** ____ Yes ____ No

IRIS: I give permission to enroll me or my child and to transfer my or my child's immunization records into the Idaho Immunizations Reminder Information System (IRIS) to ensure that this vaccination record is available to me, my or my child's health care providers and schools. I understand I may be asked for information that will help ensure my or my child's records are accurate and will not be confused with another person's records, such as: mother's maiden name, telephone number, child's gender, and child's eligibility for free vaccine. I authorize inclusion of all information into IRIS. _____ NO (do not enroll me/my child in IRIS)

Signature _____ Date _____

FINANCIAL POLICY: Effective July 1, 2009

INSURANCE: You will be responsible for balance owing on any vaccine administration fees 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# _____

Please complete other side

**SCREENING QUESTIONNAIRE FOR
SEASONAL INFLUENZA VACCINATION**

The following questions will help us determine if there is any reason we should not give your child a seasonal influenza vaccination 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

Does your child have a serious allergy to eggs?

Does your child have any other serious allergies? Please list: _____

Has your child every had a serious reaction to a previous dose of flu vaccine?

Has your child every had Guillain-Barre Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?

Has your child received a MMR, Varicella, or FluMist vaccine in the past four weeks?

Date given: month _____ day _____

Does your child have any of the following: asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood?

Is your child on long-term aspirin or aspirin-containing therapy (for example, does your child take aspirin every day)?

Does your child have a weak immune system (for example, from HIV, cancer, or medications, such as steroids or those used to treat cancer)?

Does your child have close contact with a person who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)?

Is your child pregnant or could she become pregnant within the next month?

CONSENT

I have read or had explained to me the 2009-2010 Vaccine Information Statement for the 2009 Seasonal influenza vaccine and understand the risks and benefits. **I GIVE CONSENT** to Central District Health Department and its staff for my child named on the front of this form to be vaccinated with this vaccine.

Signature of Parent/Legal Guardian _____

Date: month _____ day _____ year _____

FOR OFFICE USE ONLY

Payment Category:

Staff initials: _____

Cash Credit/Debit Card Check Number Insurance Medicaid Slide

Date _____

Nurse Signature _____

Return Date _____

(FOR NURSES USE ONLY)