

ADULT INFO SHEET

SIDNEY-SHELBY COUNTY HEALTH DEPARTMENT

Name: Last		First		Middle Initial	Birth Date	Age
Mailing Address			City	County	State	Zip
Phone	Race	Family Doctor	Employer/School		Sex: M F	

- Will you be returning to the Health Department for the next immunizations? YES NO
- Has this client had vaccines elsewhere in the past 6 months? YES NO
- Is this client ill, have any ongoing medical problems, or history of thrombocytopenia? YES NO
If YES, list them _____
- Has this client taken any medications this past week? YES NO
- Has client had a reaction to latex, neomycin, streptomycin, eggs, yeast, gelatin or past immunizations? . . YES NO
- Has this client had Immune Globulin or a blood transfusion in the last three months? YES NO
- 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
- Has this client, parents, or sibling ever had a convulsion, seizure, or history of Gullain-Barre Syndrome? . . YES NO
- Are you pregnant, think you are pregnant, or might get pregnant in the next three months? YES NO
- Has this client ever had the chickenpox disease? YES NO
Date of chickenpox disease _____ Date of titer _____
- This client: **(circle one)** 1) Is covered by Medicaid 2) Has health insurance that covers immunizations
3) Has health insurance that does not cover immunizations 4) Does not have health insurance

I have received a copy of appropriate information about the disease(s) and vaccine(s) listed 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 symptoms of an allergic reaction.** I give permission to the Sidney-Shelby County Health Department to release my immunization records to any doctor or agency when the immunization record is requested.

For Medicare Part B Recipients: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I understand I will be billed directly for payment if the Health Department is not reimbursed from Medicare.

Medicare Beneficiary Claim Number (HIC): _____

Signature of person to receive vaccine or person authorized to make the request:
X _____ **Date:** _____

***** HEALTH DEPARTMENT STAFF USE ONLY *****

VIS DATES: Hep A: 3/06 Hep B: 7/07 HPV 5/11 IPV: 1/00 Mening: 1/08 MMR: 3/08 MMRV: 5/10 PPV23: 10/09 Rabies: 10/09
Tdap/Td: 11/08 Typhoid: 5/04 Chickenpox: 3/08 Yellow Fever: 03/11 Shingles: 10/09 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	

- HIPAA notice provided
- VIS provided
- Cash
- Check

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