CHILD/ADOLESCENT IMMUNIZATION FORM

PATIENT'S NAME: _____ DATE: _____
DATE OF BIRTH: _____ AGE: _____PRIMARY PHYSICIAN_____
PHONE: _____ PARENT/GUARDIAN: _____
ADDRESS: _____
STREET OR PO BOX CITY STATE ZIP CODE
ETHINICTY: _____NO, NOT HISPANIC OR LATINO _____ YES, HISPANIC OR LATINO
RACE: __WHITE __AMERICAN INDIAN/ALASKAN __AFRICAN AMERICAN __ ASIAN__NATIVE HAWAIIAN

IMMUNIZATIONS NEEDED/ VIS STATEMENTS GIVEN:

___ TDAP ___ FLU ___ KINRIX ___ MMR ___VZV ___PEDIARIX ___ HEP B ___HEP A ___ MCV4 ___GARDISIL
___ HIB ___ PREVNAR ___ ROTATEQ ___ DTAP ___ PROQUAD ___MEN B_____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 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?	☐	☐	☐	☐
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, or anticancer drugs, or had 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?	☐	☐	☐	☐

OVER

Did you bring your child's immunization record card with you?

__ Yes (Please provide your card) __ No

It is important for you to have a personal record of your child's vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your child's vaccinations on it.

INSURANCE INFORMATION *(PLEASE PROVIDE CARD)*

As a service to you, we will bill most insurance carriers. It is important that we have updated & accurate information.

Primary Insurance Company: _____

Group # _____ **ID#** _____

Name of Insured: _____

Date of Birth_____ **Relationship to Patient** _____

Secondary Insurance Company: _____

Group # _____ **ID#** _____

Name of Insured: _____**Date of Birth**_____

Relationship to Patient _____

___No Insurance
___Insurance does not cover immunizations
___Paid with cash, check, debit/credit
___Presently on Healthy Montana Kids Plus (formerly Medicaid)
___Presently on Healthy Montana Kids (formerly CHIP)
___Other_____

Please read statements before signing this document: Thank you.

I have read or have had explained to me the information contained in the important information statements or vaccine information pamphlet(s) about the disease(s) and the vaccine(s). I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) indicated be given to me or the person named above for whom I am authorized to make this request.

X_____ _____

PARENT/GUARDIAN OR PATIENT SIGNATURE DATE

NOTICE OF ADMINISTRATIVE USE OF CONFIDENTIAL HEALTH CARE INFORMATION

I authorize my health care provider and local public health agency to collect and enter my child's immunization records into the Department of Public Health and Human Services' Immunization Information System (IIS/ImMTrax). ImMTrax is a confidential, computer system that contains health departments as well as my health care providers to assist in 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 requirements.** I understand that I can revoke this authorization and have my record removed at any time by contacting my local county health department.

X_____ _____

PARENT/GUARDIAN OR PATIENT SIGNATURE DATE

For Office Use Only:

VERBAL CONSENT GIVEN BY PARENT

NAME: _____DATE: _____

STAFF SIGNATURE: _____

STOCK: □ VFC □PRIVATE **RECORDED:** □ **BILLED:** □