THREE RIVERS
PUBLIC HEALTH DEPARTMENT
Dodge, Saunders & Washington Counties

Office Use:
Lot #: _____
Site: _____
Nurse: _____

Child and Teen Immunization Information

Last Name: _____ First Name: _____ Middle Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____
Gender: □ Female, □ Male

Date of Birth: _____ Country of Birth: _____ County of Residence: _____

Ethnicity: □White □ Black or African American □ Native Hawaiian or Pacific Islander
□ Asian □ Alaska Native □ Hispanic or Latino

Insurance:

□ No Insurance
□ Medicaid Number: _____
□Insurance Carrier:_____

Insurance Mailing Address:_____

Insured Name:_____ Your Relationship to Insured: □Self □Spouse □Child

Insured Date of Birth ___/___/____ Insured ID #:_____ Group #_____

Parent or Guardian Information (for child)

Last Name: _____ First Name: _____ Middle Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Relationship to Patient: _____ Phone Number: _____

Doctor: _____ School: _____

Mother's Maiden Last Name: _____ Mother's First Name:_____

OVER →

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you 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.

	No	Yes
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/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?	☐	☐
7. Has the child, a sibling, or a parent had a seizure; 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 treatments?	☐	☐
10. 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?	☐	☐
11. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	☐	☐
12. Has the child received vaccinations in the past 4 weeks?	☐	☐

I hereby authorize my insurance benefits to be paid directly to the clinic and acknowledge that I am financially responsible for any unpaid balance. I also authorize the clinic to release any information requested by my insurance company.

Signature of vaccination consent:_____ **Date:** _____