ANACONDA-DEER LODGE COUNTY PUBLIC HEALTH DEPARTMENT

PLEASE PRINT

(INK ONLY)

Name:_____ Birthdate:_____ Race:_____

Address:_____

(Street or Box #) (City/State) (Zip)

Telephone:_____

(Home) (Work) (Work Hours)

Social Security #_____

Insurance Information:

Blue Cross/Blue Shield_____ ACS (Medicaid of MT)_____ PHS_____ Other_____

Name of Cardholder_____ Card#_____

The Federal Government requires the statistical information asked below. All information is confidential and anonymous.

Sex: Male_____ Female_____

Race: White_____ Hispanic_____ Non Hispanic/Non Latino (all races)_____ Asian_____

Alaska Native_____ African American_____ Native American/Reservation_____

Native American/Non-Reservation_____ Native Hawaiian or other Pacific Islander_____

Other _____

I voluntarily request the services provided by Anaconda-Deer Lodge County Public Health. I understand that any services I receive here will be kept in the strictest confidence and that any transfer of my records requires my written authorization.

_____ _____

Patient's Signature Date Staff Person Date

Family Physician:_____ Allergies:_____

Previous Reactions:_____

Please read this statement and the important information statement(s) or Vaccine Information Material BEFORE signing this document. Thank you.

I have read or have had explained to me the information contained in the Important Information Statement(s) or Vaccine Information Material 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 below be given to me or to the person named above for whom I am authorized to make this request.

VACCINE(S)		Date Given (Mo/Day/Yr)	Site	Mfg./ Lot No.	Form/ Date	Patient Age	Signatures		
Other (describe)	1						Person Authorized to Make Request		Date
							Person Administering Immunization	Title	Date
	2						Person Authorized to Make Request		Date
							Person Administering Immunization	Title	Date
	3						Person Authorized to Make Request		Date
							Person Administering Immunization	Title	Date
	4						Person Authorized to Make Request		Date
							Person Administering Immunization	Title	Date

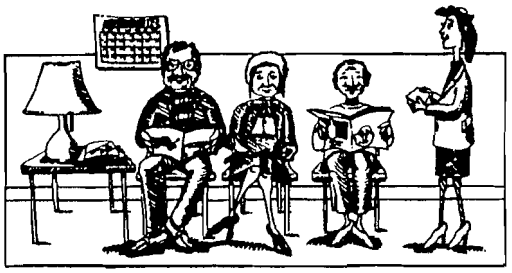
I authorize my immunization to be placed in the Montana State-wide registry.

Name:_____ Date:_____

Your name: _____

Date of birth: mo _____ day _____ year _____

Today's date: mo _____ day _____ year _____



Screening Questionnaire for Adult Immunization

The following questions will help us determine which vaccines may be given in clinic today. Please answer these questions by checking the boxes. If the question is not clear, please ask the nurse or doctor to explain it.

	Yes	No	Don't Know
1. Are you sick today?	❑	❑	❑
2. Do you have allergies to medications, eggs, any vaccine, or any vaccine component?	❑	❑	❑
3. Have you ever had a serious reaction after receiving a vaccination?	❑	❑	❑
4. Do you, any person who lives with you, or any person you take care of have cancer, leukemia, AIDS, or any other immune system problem?	❑	❑	❑
5. Do you, any person who lives with you, or any person you take care of take cortisone, prednisone, other steroids, anticancer drugs, or x-ray treatments?	❑	❑	❑
6. During the past year have you received a transfusion of blood or plasma, or been given a medicine called immune globulin?	❑	❑	❑
7. For women: Is it possible that you are pregnant or may become pregnant in the next three months?	❑	❑	❑

Did you bring your immunization record card with you?

yes ❑ no ❑

It is important for you to have a personal record of your shots. If you don't have a record card, ask your doctor or nurse to give you one! Bring this record with you to your clinic visits. Make sure your clinic records all your vaccinations on it.

Item #P4065 (2/97)

Immunization Action Coalition • 1573 Selby Avenue • St. Paul, MN 55104 • 651-647-9009 • www.immunize.org