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:_____

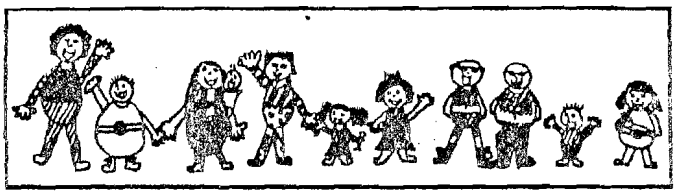
Please read this statement and the important information statement(s) or Vaccine Information Material BEFORE signing this document. Thank you.

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:_____



Child's name: _____

Date of birth: mo _____ day _____ year _____

Today's date: mo _____ day _____ year _____

Screening Questionnaire for Child and Teen Immunization

For parents and guardians: This form helps us decide which vaccines should 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. Is the child sick today?	☐	☐	☐
2. Does the child have allergies to medications, eggs or any vaccines?	☐	☐	☐
3. Has the child had a serious reaction to a vaccine in the past?	☐	☐	☐
4. Has the child had a seizure or a neurological problem?	☐	☐	☐
5. Does the child or anyone who lives with the child or takes care of the child have cancer, leukemia, AIDS, or any other immune system problem?	☐	☐	☐
6. Does the child or anyone who lives with the child or takes care of the child take cortisone, prednisone, other steroids, anticancer drugs, or x-ray treatments?	☐	☐	☐
7. Has the child received a transfusion of blood, plasma, or a medicine called immune globulin in the past year?	☐	☐	☐
8. Is the child pregnant or at risk for becoming pregnant within the next three months?	☐	☐	☐

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

It is important for you to receive a personal record of your child's shots. If you don't have a record card, ask the child's doctor or nurse to give you one! Bring this record with you every time you bring your child to the clinic. Make sure your clinic records all vaccinations on it. Your child will need this card to enter daycare, kindergarten, junior high, etc.

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