ADLC- PUBLIC HEALTH,118 E 7th ST, ANACONDA, MT 59711 (406) 563-7863
PUBLIC HEALTH SERVICE RECORD

Client: _____ _____ _____/_____/_____ _____/_____/_____
(LAST) (FIRST) (MI) (AGE) (DATE OF BIRTH) (DATE OF SERVICE)

VFC _____ Private ____

Check if Provided	**PEDIATRIC** Vaccine/Service	DX Code CPT Code	Price*		Check if Provided	**ADULT** Vaccine/Service	DX Code CPT Code	Price*
	DTaP	Z23 90700	50.00			Flu-IM (age 3& up)	Z23 90688	26.50
	DTaP- Hep B-IPV	Z23 90723	73.00			Fluad	Z23 90694	67.00
	DTaP-IPV(ages 4-6yrs) **Kinrix**	Z23 90696	56.00			FluBlok	Z23 90682	55.00
	DTaP-IPV-HIB	Z23 90698	82.00			Hep. A	Z23 90632	81.00
	Flu-IM (6 mo & up)	Z23 90688	26.50			Hep. A & B Combo	Z23 90636	93.00
						Hep. B	Z23 90746	71.00
						HPV	Z23 90649	275.00
	Hep. A (1-18yrs)	Z23 90633	39.00			MCV4 Meningococcal	Z23 90733	127.00
	Hep. B (birth-19 yrs.)	Z23 90744	35.00			Men –B Bexsero	Z23 90620	178.00
	Hep. B HIB	Z23 90748	45.00			Men-B Trumenba	Z23 90621	VFC
	HIB	Z23 90648	27.00			MMR	Z23 90707	97.00
	HPV	Z23 90649	275..00			PCV 13 Prevnar	Z23 90670	234.00
	IPV (Polio)	Z23 90713	42.00			PPV 23	Z23 90732	120.00
	Kinrix	Z23 90696	56.00			Rabies Vaccine	Z23 90675	360.00
	MCV4 Meningococcal	Z23 90733	147.00			TB Test	V74.1 86580	13.00
	Men-B Bexsero	Z23 90620	200.00			Td	Z23 90714	22.00
	Men-B Trumenba	Z23 90621	VFC			Tdap (age 7 &up)	Z23 90715	50.00
	MMR	Z23 90707	97.00			Typhoid-IM	Z23 90691	153..00
	MMR-V	Z23 90710	250.00			Typhoid-Oral	Z23 90690	98.00
	PCV 13 Prevnar	Z23 90670	224.00			Yellow Fever	Z23 90717	75.00
	Rotavirus (Rota-Teq)	Z23 90680	76.00			Shinrix	Z23 90750	187.00
	Rotavirus (Rotarix)		107.00			Hemoglobin	85018	4.00
	Tdap (age7 & up)	Z23 90715	50.00			**Other**		
	Varicella	Z23 90716	130.00			Lead Level (>12 months)	V15.86 83655	17.00
	IZ 1st Shot <18 yrs PVT/VFC	90460	21.32			IZ 1st Shot ≥ 18 yrs.	90471	21.32
	IZ ADTL Shot <18 yrs PVT/VFC	90461	21.32			IZ ADTL Shot ≥18 yrs.	90472	21.32

Information on vaccines can be found at the CDC web site www.cdc.gov/vaccines/hcp/vis/current-vis.html

Updated 9/7/2022

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Vaccine Record

Client: _____ ____ _____/_____/_____ **VFC** ___ **Private** ___
(LAST) (FIRST) (MI) (AGE) (DATE OF BIRTH)

_____ _____ _____
(ADDRESS) (CITY) (STATE) (ZIP) (PRIMARY PHONE)

Primary Reason for visit:
O Immunization
O Lead Test
O Nurse Consult

O TB Test
O Other_____

Gender
O Male
O Female
O Other

Hispanic/Latino
O Yes
O No

Limited English
O Yes
O No

Race
O African American
O Alaskan Native
O American Indian
O Asian
O Native Hawaiian/Pacific Islander
O White
O Unknown/Not Reported/Other_____

Date of Service:____/____/___
Insurance Status:
O Insured
O Underinsured
O Medicare/Medicaid
O Uninsured
O Self Pay
O Fee Scale

Health History: Primary Physician: _____ Allergies: _____

Client Authorization: I voluntarily request the below initialed vaccine services provided by the ADLC-Public Health Department on the dates listed. I understand that these services are kept in strict confidence and that any transfer of these records requires my written authorization. I acknowledge that I am responsible for any outstanding balances.

X_____ **X** _____ **X** _____
(Client or Guardian's Signature) (**PRINT** Client or Guardian Name) (Date)

I authorize electronic preservation of the vaccine records in the Montana State Registry: **X**_____
(Initials)

Additional Client Information if Client is a Minor:

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

Other: _____

I give permission for the child above to receive the fluoride varnish from an RN employed at ADLC- Public Health Department. This child has no known sensitivity or allergy to *FLUORIDE*. I have read the information about caries and oral health risks. I understand the benefits and risks of the fluoride varnishes, and that the exam is limited to visualization of the child's teeth.

X _____ **X** _____
(Client or Guardian's Signature) (Date)

Vaccinator Signatures and Initials:

_____ _____ _____ _____

_____ _____ _____ _____

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