Fairfield Department of Health
Immunization Clinic

CHILDREN / TEEN PATIENT REGISTRATION
(18 years or younger)

Patient Information			
First Name	Last Name	MI	Date of Birth
Address	City	State	Zip
Please check Primary phone	Home Phone ☐	Work Phone ☐	Cell Phone ☐
Other Name(s) Used	E-mail Address		
Gender ☐ M ☐ F	SSN	Preferred Language	Driver's License

Marital Status	Preferred Contact	Ethnicity	Race
☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Life Partner	☐ Mail ☐ Home Phone ☐ Day Phone ☐ Cell Phone ☐ Patient Portal (MyChart)	☐ Cambodian ☐ Filipino ☐ Hispanic/Latino ☐ Non-Hispanic	☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other

Primary Care Provider	Referring Provider

Responsible Party (Guarantor) ☐ Same as patient			
First Name	Last Name	MI	Date of Birth
Address	City	State	Zip
Please check Primary Phone	Home Phone ☐	Work Phone ☐	Cell Phone ☐
SSN	Relationship to Patient	Preferred Language	Driver's License

Emergency Contact (for minor child, this section may be used for other parent)			
First Name	Last Name	MI	Date of Birth
Address	City	State	Zip
Please check Primary Phone	Home Phone ☐	Work Phone ☐	Cell Phone ☐

Immunization Record Release Authorization:

I authorize the Fairfield Department of Health to release Immunization Records via mail, fax, or email to *(check all that apply)*:
☐ Physicians ☐ Schools/Preschools ☐ Daycare Facilities ☐ Other _____

_____ _____
Signature of Patient or Responsible Party Date

Consent for Additional Party to bring child in absence of parent. (*Optional*)

I (Parent/Guardian Name) _____ am authorizing (Authorizing Party) _____
to bring my child (Child's Name) _____ to any upcoming appointments he/she may have.

Parent/Guardian Signature _____ Date _____

****Please be advised that this statement will not change unless you submit in writing requesting the person you authorized to be removed. Only valid for one year from date signed.**

Financial Consent/Insurance Information:

Primary Ins. Name: _____ Secondary Ins. Name: _____
(e.g. Medicaid, Care Source, Molina, TriCare, UHC-state insurance card, Medigold, Medicare, Paramount, Buckeye, Private Insurance).

Please initial by each statement:.

_____I authorize the Fairfield Department of Health to release pertinent information to my insurance company when requested, or to facilitate payment of a claim.

_____I authorize the Fairfield Department of Health to apply for benefits on my behalf for covered services rendered by the patient and for payment to be made payable to the Fairfield Department of Health.

_____I agree to bring the most current copy of my insurance card with me to each visit and will pay all applicable co-pays or deductibles on the same day I receive medical services.

_____I agree with the consent and the provisions of medical treatment and the financial policy.

_____I understand that the services provided may or may not meet the criteria for coverage under Medficare, Medicaid, and/or other insurance carriers.

_____My initials indicate that I agree to pay all charges/unpaid deductibles regarding this service(s) if Medicare, Medicaid, and/or other private insurance carriers fail to cover the charges.

_____ I hereby declare that I/we do not have any other valid and collectible insurance or indemnity coverage, including, but not limited to, private/supplemental medical insurance, Medicare, or other Medicaid insurances(Ex: Molina, CareSource, Paramount Advantage, etc.) that were in effect during the office visit. (if applicable)

****Please provide your Insurance Card to be copied and placed in your file****

Directions:

Please answer the 4 questions to the **RIGHT.**

VFC Eligibility Determination

1.	Receive Medicaid (ex: Caresource, Molina, etc)	□ Yes	□No
2.	Uninsured	□ Yes	□No
3.	American Indian / Alaska Native	□ Yes	□No
4.	Underinsured – defined below*	□ Yes	□No

***The "Underinsured" category is very narrowly defined for children to be eligible for VFC vaccine in Local Health Departments and Federally Qualified Health Centers. Patients with high deductible or high co-payment costs are never considered "Underinsured."**

For Office Use Only

VFC Eligibility Yes □ No □
Nurse / Clerk Initials _____

Acknowledgment of Receipt of Notice of Privacy Practices:

I acknowledge that I have reviewed a copy of the Notice of Privacy Practices provided to me by the Fairfield Department of Health. I understand that this Notice explains what the Fairfield Department of Health does to protect the use or disclosure of my health care information. I understand that I may request a copy of this Notice to be given to me and will refer to it if I have questions. I also understand that I should call the Health Department at (740) 652-2800 if I have questions or concerns about my privacy rights.
_____ (Initial)

****All Signatures are valid for 1 (one) year.****

Screening Checklist for Contraindications to HPV, MenACWY, MenB, and Tdap Vaccines for Teens

YOUR NAME _____

DATE OF BIRTH ____ / ____ / ____
month day year

For parents/guardians: The following questions will help us determine if human papillomavirus (HPV), meningococcal conjugate (MenACWY), meningococcal serogroup B (MenB), and tetanus, diphtheria, and acellular pertussis (Tdap) vaccines may be given to your teen today. If you answer "yes" to any question, it does not necessarily mean your teen 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
1. Is your teen sick today?	☐	☐	☐
2. Does your teen have allergies to a vaccine component or to latex?	☐	☐	☐
3. Has your teen had a serious reaction to a vaccine in the past?	☐	☐	☐
4. Has your teen had brain or other nervous system problems?	☐	☐	☐
5. For females: Is your teen pregnant?	☐	☐	☐

FORM COMPLETED BY _____ DATE _____

FORM REVIEWED BY _____ DATE _____

Did you bring your teen's immunization record card with you? **yes** ☐ **no** ☐

It is important to have a personal record of your teen's vaccinations. If you don't have one, ask your healthcare provider to give you one with all of your teen's vaccinations on it. Keep it in a safe place and be sure your teen carries it every time he/she seeks medical care. Your teen will likely need this document to enter school or college, for employment, or for international travel.

immunization action coalition
IAC
immunize.org

Technical content reviewed by the Centers for Disease Control and Prevention

Saint Paul, Minnesota ▪ 651-647-9009 ▪ www.immunize.org ▪ www.vaccineinformation.org

www.immunize.org/catg.d/p4062.pdf ▪ Item #P4062 (3/16)

Information for Healthcare Professionals about the Screening Checklist for Contraindications to HPV, MenACWY, MenB, and Tdap Vaccines for Teens

Are you interested in knowing why we included a certain question on the screening checklist? If so, read the information below. If you want to find out even more, consult the references listed at the end.

1. Is your teen sick today?
(This question applies to HPV, MenACWY, MenB, Tdap.)

There is no evidence that acute illness reduces vaccine efficacy or increases vaccine adverse events.[1,2] However, all vaccines should be delayed until a moderate or severe acute illness has improved. Mild illnesses (such as otitis media, upper respiratory infections, and diarrhea) are NOT contraindications or precautions to vaccination. Do not withhold vaccination if a teen is taking antibiotics unless he/she is moderately or severely ill.

2. Does your teen have allergies to a vaccine component or to latex?
(This question applies to HPV, MenACWY, MenB, Tdap.)

A delayed-type local reaction following a prior vaccine dose is not a contraindication to a subsequent dose. History of severe allergy to a vaccine component occurs in minutes to hours, requires medical attention, and is a contraindication. For a table of vaccine components, go to www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/excipient-table-2.pdf. For a table of vaccines supplied in vials or syringes that contain latex, go to www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/latex-table.pdf.

3. Has your teen had a serious reaction to a vaccine in the past?
(This question applies to HPV, MenACWY, MenB, Tdap.)

A local reaction following a prior vaccine dose is not a contraindication to a subsequent dose. However, history of an anaphylactic reaction (hives, swelling of the lips or tongue, acute respiratory distress, or collapse) following a previous dose of vaccine or vaccine component is a contraindication for subsequent doses.[1]

4. Has the teen had brain or other nervous system problems?
(This question applies to Tdap.)

Tdap is contraindicated in teens who have a history of encephalopathy within 7 days following DTP/DTaP. An unstable progressive neurologic problem is a precaution to the use of Tdap. Under normal circumstances, vaccines are deferred when a precaution is present. However, situations may arise when the benefit of vaccinating outweighs the risk (e.g., during a community pertussis outbreak). For teens with stable neurologic disorders (including seizures) unrelated to vaccination, or for those with a family history of seizures, vaccinate as usual. A history of Guillain-Barré syndrome (GBS) is a consideration with Td or Tdap: if GBS occurred within 6 weeks of receipt of a tetanus-containing vaccine and a decision is made to continue vaccination, give age-appropriate Tdap instead of Td if there is no history of a prior Tdap dose, to improve pertussis protection.

5. For females; Is your teen pregnant?
(This question applies to HPV.)

Teens who are pregnant should not be given HPV vaccine. However, pregnancy is not a contraindication or precaution for administering Tdap, MenACWY, or MenB vaccine.

REFERENCES

1. CDC. *General Recommendations on Immunization: Recommendations of the Advisory Committee on Immunization Practices (ACIP)* at www.cdc.gov/vaccines/pubs/acip-list.htm.
2. AAP. *Red Book: Report of the Committee on Infectious Diseases* at www.aapredbook.org.