Monroe County Public Health Clinic
333 E Miller Dr
Bloomington, IN 47401
812-353-3244

PATIENT INFORMATION:

Patient Name (First, Last) _____ **DOB** ____/____/_____

Race _____ **Gender**_____

Parent/Guardian Name (First, Last) _____

Phone Number _____ **Email**_____

Address (City/State/Zip)_____

INSURANCE INFORMATION:

Private *Medicare* *Medicaid* *No Health Insurance* ***(circle all that apply)***

Insurance Name _____ **Policy Holder (Insured's Name)** _____

Policy Holder's Date of Birth ____/____/____ **Policy Number** _____

Group Number _____

CONSENT: I authorize Monroe County Public Health Clinic to administer treatment as deemed necessary for care of the patient named above. I certify that I am the patient, parent or legal guardian of the patient. I also authorize payment of medical benefits to Vaxcare, and the release of any information necessary to process the claim.

REVIEW OF THE VACCINE INFORMATION SHEETS (VIS): I acknowledge that I have been given an opportunity to review and take home copies of VIS available upon request.

My signature indicates agreement to the above and that all information provided above is true and accurate:

_____ _____ _____

Signature of Patient or Legal Representative *Print Name* *Date*

STAFF USE ONLY

VACCINE	LOT	SITE	ROUTE	VAX'd	CHIRP'd	Logged

VACCINATOR SIGNATURE:_____ **DATE:**_____

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SCREENING CHECKLIST

	YES	NO
1. Is the patient currently sick?		
2. Does the patient have any allergies to medications, foods, vaccine components, or latex?		
3. Has the patient ever had a serious reaction to a vaccine in the past?		
4. Does the patient have a long-term health problem with lung, heart, kidney, diabetes, asthma, blood disorder, no spleen, complement component deficiency, cochlear implant, or spinal fluid leak? On long-term aspirin therapy?		
5. Is the patient 2 through 4 years of age, and been told that they have wheezing or asthma within the last 12 months?		
6. Is the patient a baby that has been told he or she has intussusception?		
7. Does the patient, their sibling(s), or their parent(s) have a history of seizures or any other nervous system problems?		
8. Does the patient have a history of cancer, leukemia, HIV/AIDS, or any other immune system problems?		
9. Does the patient, their parent(s), or their sibling(s), have an immune system problem?		
10. In the past three months, has the patient taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis, or had radiation treatments?		
11. In the past year, has the patient received a transfusion of blood or blood products, or been given immune (gamma) globulin or antiviral drug?		
12. Is the patient pregnant or is there a chance they could become pregnant during the next month?		
13. Has the patient received vaccinations in the past 4 weeks?		
14. Has the patient had a seizure or a brain or other nervous system problem?		

If yes to any of the above, please explain:

_____

_____

_____

FORM COMPLETED BY: _____ *(SIGNATURE)* **DATE:** _____