Patient Information/Computer Form

Today's Date: ________________________

Child's Name: ________________________ Sex: _______ Date of Birth: ____________Age: ________

Street Address: _______________________ City: ___________________ State: _______Zip: ________

Parent/Guardian: ____ Phone: _________________

Allergies: ____Physician: ____________________________

Previous serious vaccine reactions: ____

The Federal "Vaccines for children" (VFC) Program requires that we keep statistics on all children immunized in our clinics. In order to comply with this, we ask you to respond to the following questions. **(All information is confidential)**

1. Race (Please circle) Caucasian 1 Asian/Pacific Islander 4 Hispanic 5 Black 2
   American Indian/Alaskan Native 3 Other 7 Unknown 9

2. Is child on HMK/HMK Plus? Yes No If yes, please attach a copy of your card to completed form.

3. Is child covered by medical insurance? Yes No
   If yes, are immunizations covered? Yes No
   If yes, attach a copy of your insurance card (front and back)

I give permission for my child to receive Hep A HPV Meningococcal (MCV4)

I have read or had explained to me the information contained in the Vaccine Information Statement(s) about the disease(s) and the vaccine(s) and request the vaccine(s) indicated above be given to me or the person named above for who I am authorized to make this request. I authorize my health care provider and a public health agency to collect and enter my child's immunization records into the Department of Public Health and Human Services' Immunization Information System (IIS). The IIS is a confidential, computer system that contains immunization records. I understand that information in the registry may be released to a public health agency as well as my health care providers to assist in my child's medical care and treatment. In addition, information may be released to child care facilities and schools in which my child is enrolled to comply with state immunization requirements. I understand that I can revoke this authorization and have my record removed at any time by contacting my local health department.

____ ________________________

Signature of Parent or Guardian Date

CHECK PAYMENT SOURCE

Cash Check

HEALTHY MT KIDS/ HMK PLUS

PRIVATE INSURANCE

For Office Use Only:

Vaccine	Body site	Immune Date	Mfg. Lot #	Form Date	Nurse signature
MCV4					
HPV					
Hep A					

TURN OVER TO COMPLETE

SCREENING QUESTIONNAIRE FOR IMMUNIZATIONS

Please complete all blanks on this medical history form. Write N/A (not applicable) if indicated:

1. Are you sick today? Yes No

2. Are you taking any medications today, If YES please list ____________________ Yes No

3. Do you have any specific allergies to medications, food, or any vaccines? Yes No
   If YES, please list ________________________________
   Are you allergic to: (Circle each that applies)
   Eggs Baker's Yeast Neomycin Streptomycin Gelatin Formaldehyde Thimerosal

4. Have you ever had a serious reaction after receiving a vaccination? Yes No
   If yes, what type of reaction:_________________________________

5. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation or chemotherapy? Yes No

6. Do you have cancer, leukemia, AIDS or any other immune system problem? Yes No

7. Has the child had a seizure or a brain problem or other nervous system problems? Yes No

8. Are you or anyone in your immediate family undergoing treatment for cancer (chemotherapy or radiation) or in any way have severe problems fighting off illnesses? Yes No

9. In the past year, have you been given immune globulin or any blood products recently or have you been given a medicine called immune (gamma) globulin? Yes No

10. Are you pregnant or planning to become pregnant in the next month? Yes No

11. Have you received any vaccinations in the past 4 weeks? Yes No