



*"To improve the health of our communities by identifying sustainable solutions to community health issues, developing partnerships for implementation of strategies, and demonstrating our success through measurement of outcomes."*

Dear Parents:

Central District Health Department (CDHD) will be providing an immunization record assessment and administering all age appropriate childhood vaccines on June 5, 2014 at **Athletic pre-participation physical exams**. The event is hosted at Boise State University (BSU) Caven-Williams Sports Complex. Your child's vaccination status will not impact their eligibility to play sports. This is an opportunity to get your child updated on the recommended and required vaccines for school.

**Please send your child's immunizations records with them to Athletic pre-participation physical exams!**

#### **What should your child expect?**

CDHD staff will assess your child's immunization record (based solely on the records provided to us during the physicals). A completed immunization review form and vaccine information statement will be sent home with your child. (<http://www.cdc.gov/vaccines/hcp/vis/index.html>)

#### **What should parents do?**

**If you would like your child to receive any age appropriate childhood vaccines at the Athletic pre-participation physical exams event, please follow these steps:**

- a) Complete the attached forms: Client Information Form and Medical History Form
- b) **ALL** questions **MUST** be answered; CDHD will not vaccinate students with incomplete paperwork
- c) **SIGN AND DATE** the forms where indicated with an **X** \_\_\_\_\_
- d) **SEND** the **Forms**, your child's **immunization record**, and a copy of your **insurance card** with your child to the event on June 5, 2014.
- e) **DO NOT** return the forms if you **do not** wish your child to be vaccinated at the clinic.

**What is the cost?** There is no cost for the vaccine; however, there is an administration fee. CDHD will bill your Insurance/Medicaid for the administration fee(s). If you do not have insurance, we will bill you directly at a cost of **\$20.13** per vaccine, up to 4 vaccines. No one will be denied vaccination due to inability to pay. If you have any questions regarding this vaccination program, **please direct all calls to Central District Health Department at 327-8586**. Other staff at the event will not be able to answer any questions pertaining to the vaccination clinic.

Sincerely,

Vinci Anderson, RN  
Central District Health Department  
707 N. Armstrong Place  
Boise, ID 83704  
[vanderso@cdhd.idaho.gov](mailto:vanderso@cdhd.idaho.gov)  
208-327-8586



CLIENT INFORMATION FORM

CLIENT DEMOGRAPHIC INFORMATION

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_ SS# (optional) \_\_\_\_\_

Name (First) \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Mailing Address \_\_\_\_\_

Zip \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Optional: Email \_\_\_\_\_ Texting Number  Yes  No

Gender  Female  Male At birth were you a:  Single  Twin  Triplet  Other

Race  White  American Indian  Black  Alaskan Native  Asian  Hawaiian—Pac Islander  Other Ethnicity  Hispanic  Not Hispanic  Unknown

Language  English  Spanish  Other \_\_\_\_\_ Limited English Proficiency  Yes  No

Mother's Maiden Name \_\_\_\_\_ Client Alias \_\_\_\_\_

PARENT/GUARDIAN INFORMATION SS# (optional) \_\_\_\_\_

Name (First) \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

PRIMARY INSURANCE  None Patient's relationship to insured:  Self  Spouse  Child

Insurance Company: \_\_\_\_\_ Name of Primary Insured: \_\_\_\_\_

Insured Date of Birth: \_\_\_\_\_ Insured Phone: \_\_\_\_\_

ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's address if different from above: \_\_\_\_\_

MEDICAID INFORMATION

Name (as printed on card): \_\_\_\_\_ Medicaid # \_\_\_\_\_

ALL CLIENTS PLEASE READ THE FOLLOWING AND INITIAL

\_\_\_\_\_ I acknowledge that I was given a copy, and I have read, or had explained to me the Central District Health Department Notice of Privacy Practices.

\_\_\_\_\_ I acknowledge that I was given a copy, and I have read, and understand the Financial and Appointment Policy.

\_\_\_\_\_ I need financial assistance. My household size \_\_\_\_\_ My monthly income \_\_\_\_\_

\*\*\*Monthly gross income (DO NOT LEAVE BLANK, DO NOT ENTER 0)\*\*\*

\_\_\_\_\_ I understand that childhood immunizations are not mandatory and may be refused on religious or other grounds.

\_\_\_\_\_ Participation in and withdrawal from the Immunization Registry (IRIS) is voluntary. Call Idaho Immunization Program at 208.334.5931 to opt-out or withdraw. If you do not opt-out of IRIS in writing, your child's immunization records will be stored in the registry.

Signature of person receiving vaccine or the person authorized to make the request:

SIGNATURE X \_\_\_\_\_ DATE X \_\_\_\_\_



## IMMUNIZATIONS FINANCIAL & APPOINTMENT POLICY

The goal of our clinic is to provide you with quality health care at a reasonable cost. Central District Health Department is **not a free clinic**. Some fees are offered on a sliding scale based upon income and family size. In order to remain affordable, we depend upon you to make prompt payments for services. In an effort to do this, we have implemented a Financial Policy. This Financial Policy shares responsibility among all our clients. By initialing the lines below you acknowledge you have read, understand and agree to these terms.

### **I understand Central District Health**

- Will not deny services for inability to pay
- Accepts cash, checks, credit cards, Medicaid, and private insurance
- Offers a payment plan. We require \$10 minimum monthly per account on outstanding balances. Payments of less than \$30 in three months will result in the account being turned over to a collection agency.
- Will continue providing me services if I have an account balance
- Does not charge for most state supplied vaccines; however, there may be exceptions please ask for specific vaccines
- Charges an administration fee for each vaccine

**Private Insurance Companies and/or Medicaid:** Please read the following information that will be important to you if you are currently covered by a private health insurance company and/or Medicaid.

- Please present your insurance and/or Medicaid card at the reception desk.
- Central District Health Department will bill your health insurance provider for you and the payment may come directly to the Health Department.
- **You are responsible for all charges not paid by your insurance company, including deductibles and co-pays.** We require \$10 minimum monthly payments per account on outstanding balances. Payments of less than \$30 in three months will result in the account being turned over to collection.
- Your medical information, necessary to process your claim, will be provided to your health insurance provider.
- We are not a Medicare provider and cannot bill Medicare for any services.
- **By your acceptance of the services provided here today, you agree that you are responsible for all charges not paid by your insurance company.**
- After you receive your Explanation of Benefits from your insurance company or after you receive your bill from us, please call us at **327-8594** if you have questions about the balance on your account.

**Appointment Policy:** We will work hard to accommodate appointments that fit your schedule and medical needs. We ask that you let us know about cancellations or changes twenty-four hours in advance by calling 327-7450 for Boise, 634-7194 for McCall, or 587-4407 for Mt. Home.

I hereby acknowledge that I was given a copy and I have read or had explained to me the Central District Health Department Immunizations Financial & Appointment Policy.

## **Central District Health Department Notice of Privacy Practices**

**THIS NOTICE DESCRIBES HOW PROTECTED MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

1. *Central District Health Department* is permitted to make uses and disclosures of protected health information for treatment, payment and health care operations including, but not limited to, those uses as described in the following examples:
  - a. For treatment – For example, your protected health information will be used when sharing immunization records with another healthcare provider to determine what immunizations are needed at the time of service.
  - b. For payment – For example, your protected health information will be used, as needed, to obtain payment from insurance, Medicaid or Medicare for services received by you.
  - c. For health care operations – For example, your protected health information will be used to support ongoing healthcare operations such as chart audits and quality assurance activities.
2. *Central District Health Department* is permitted or required, under specific circumstances, to use or disclose protected health information without your written authorization. Examples included, but not limited to those uses listed above and also reporting of child abuse situations and reporting communicable diseases.
3. Other uses and disclosures not described in this notice will be made only with your written authorization, and you may revoke such authorization. For example: psychotherapy notes, marketing, and sale of information.
4. *Central District Health Department* intends to engage in the following activities:
  - a. *Central District Health Department* may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
5. *Central District Health Department* must notify you if your unsecured protected health information has been breached unless there is a low probability that it has been compromised.
6. You have the following rights regarding protected health information:
  - a. The right to request restrictions on certain uses and disclosures of protected health information. Central District Health Department is not required to agree to a requested restriction, however.
  - b. The right to limit disclosures to health inquiries if you paid in full for the relevant care at the time of the visit.

- c. The right to receive confidential communications of protected health information, as applicable.
  - d. The right to inspect and copy protected health information, as provided in the Privacy Regulation.
  - e. The right to amend protected health information, as provided in the Privacy Regulation.
  - f. The right to receive an accounting of disclosures of protected health information.
  - g. The right to obtain a paper copy of this Notice from Central District Health Department upon request. This right extends to an individual who has agreed to receive the Notice electronically.
7. *Central District Health Department* is required by law to maintain the privacy of protected health information and to provide you with notice of its legal duties and Privacy practices with respect to protected health information.
  8. *Central District Health Department* may disclose limited demographic protected health information for fundraising purposes; however, you have the right to opt out of the fundraising activity and will not jeopardize your receiving care.
  9. *Central District Health Department* is required to abide by the terms of the Notice currently in effect.
  10. *Central District Health Department* reserves the right to change the terms of this Notice. The new Notice provisions will be effective for all protected health information that it maintains.
  11. *Central District Health Department* will provide you with a revised Notice.
  12. You may complain to Central District Health Department and to the Secretary of the Department of Health and Human Services, without fear of retaliation by the organization, if you believe your privacy rights have been violated.
  13. *Central District Health Department's* contact person for matters relating to complaints is:
    - a. *Lorraine Fortunati*, Preventive Health Services Coordinator, 208-327-8618, Central District Health Department, 707 N. Armstrong Place, Boise, Idaho 83704.
  14. This Notice is first in effect on 4/14/03.

I hereby acknowledge that I have received a copy of Central District Health Department's Notice of Privacy Practices.

\_\_\_\_\_  
Individual's Name

Date: \_\_\_\_\_



## Medical History Form

The following questions will help us determine which vaccines you may be given today. If a question is not clear, please ask a health care provider to explain it.

**PLEASE MARK ANSWER**

Is the patient sick today?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NOT SURE
Does the patient have any known allergies to medications, food, vaccine component or latex? (For example: eggs) Please list: _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NOT SURE
Has the patient ever had a serious reaction after receiving a vaccine? (Routine or Flu vaccines)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NOT SURE
Has the patient ever had Guillain-Barre Syndrome (a type of temporary, severe muscle weakness), seizures or neurological disorders?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NOT SURE
Does the patient have cancer, leukemia, HIV/AIDS, immune system problems, or have close contact with a person who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NOT SURE
Does the patient take cortisone, prednisone, other steroids, or anti-cancer drugs, or has the patient had radiation treatments? Long term aspirin therapy? Daily aspirin dose _____.	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NOT SURE
During the <b>past year</b> , has the patient received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin? If yes, when? month _____ day _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NOT SURE
Has the patient received a MMR, Varicella, Rotavirus, or FluMist vaccine in the <b>past four weeks</b> ? If yes, when? month _____ day _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NOT SURE
Does the patient have any of the following: asthma, wheezing, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood? Is the patient on long-term aspirin therapy?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NOT SURE
Has the patient had chickenpox? If yes, when? _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NOT SURE
Does your family have a dentist?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NOT SURE
Has your child seen a dentist in the last year?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NOT SURE
<b>For females:</b> Are you pregnant or is there a chance you could become pregnant during the next month?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NOT SURE

Circle ALL that apply:  
 Medicaid / No Insurance / Insurance / American Indian / Alaskan Native / Underinsured

I have received the vaccine information statement (s) for vaccines being administered at this visit. I understand the benefits and risks of the vaccine (s) and request that they be administered to me or my child as authorized by the signature below.

I've been informed about the circled vaccines and I choose not to have my child/self vaccinated with them today.  
 Dtap / Flu / Hep A / Hep B / HIB / HPV / Meningitis / MMR / PCV 13 / Polio / Rotavirus / Tdap / Varicella

\_\_\_\_\_ Yes, the patient will return to CDHD for immunizations      \_\_\_\_\_ No, the patient will return to their physician for immunizations

**Signature of person completing form: X** \_\_\_\_\_ **Date: X** \_\_\_\_\_ **Nurse:** \_\_\_\_\_

**I have reviewed the information above and made changes if indicated.**

I have received the vaccine information statement (s) for vaccines being administered at this visit. I understand the benefits and risks of the vaccine (s) and request that they be administered to me or my child as authorized by the signature below.

I've been informed about the circled vaccines and I choose not to have my child/self vaccinated with them today.  
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\_\_\_\_\_ Yes, the patient will return to CDHD for immunizations      \_\_\_\_\_ No, the patient will return to their physician for immunizations

**Signature of person completing form:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Nurse:** \_\_\_\_\_

