

# SPECIAL EVENT IMMUNIZATION CONSENT FORM

Student's Name Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: M or F

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Message: \_\_\_\_\_

Parent/Legal Guardian's Name: \_\_\_\_\_ Mother's Maiden Name \_\_\_\_\_

School Name: \_\_\_\_\_ Grade \_\_\_\_\_

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

**Circle all that apply** \*Ages 0-18 yrs only\*

Medicaid / No Insurance / Insurance / American Indian / Alaskan Native

**Medicaid Information**

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

**Primary Insurance**

Patient's relationship to insured: Self Spouse Child

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

Primary Insured's Date of Birth: \_\_\_\_\_ Insured Phone: \_\_\_\_\_

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

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

**PLEASE READ AND INITIAL:**

\_\_\_\_\_ Central District Health Department will bill your health insurance or Medicaid.

\_\_\_\_\_ IF YOU DO NOT have insurance you will be billed directly for the administration fee(s).

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

\_\_\_\_\_ I acknowledge that I was given a copy, and I have read the Central District Health Department Notice of Privacy Practices and Financial Policy (see attached)

For billing questions please call our Finance Department at 327-8594.

**FOR OFFICE USE ONLY**

Payment Category: \_\_\_\_\_

Staff initials: \_\_\_\_\_

Insurance

Medicaid

Other

**PLEASE COMPLETE OTHER SIDE.**

**Child will not be vaccinated, if back side is not completed**

## IMMUNIZATION SCREENING QUESTIONNAIRE

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 circle YES or NO

Is the patient sick today?	YES	NO
Does the patient have allergies to medications, food, or any vaccine? (For example: eggs) Please list: _____	YES	NO
Has the patient ever had a serious reaction after receiving a vaccine? (Routine or Flu vaccines)	YES	NO
Has the patient ever had Guillain-Barre Syndrome (a type of temporary, severe muscle weakness), seizures or neurological disorders?	YES	NO
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)?	YES	NO
Does the patient take cortisone, prednisone, other steroids, or anti-cancer drugs, or has the patient had x-ray treatments? Long term aspirin therapy? Daily aspirin dose _____.	YES	NO
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 _____	YES	NO
Has the patient received a MMR, Varicella, Rotavirus, or FluMist vaccine in the <b>past four weeks</b> ? If yes, when: month _____ day _____	YES	NO
Does the patient have any of the following: asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood?	YES	NO
Has the patient had chickenpox? If yes, when? _____	YES	NO
Does the patient smoke?	YES	NO
<b>For females:</b> Are you pregnant or is there a chance you could become pregnant during the next month?	YES	NO

### ALL CLIENTS: PLEASE READ THE FOLLOWING, INITIAL, SIGN AND DATE

\_\_\_\_\_ 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.

\_\_\_\_\_ I have read or had explained to me the Vaccine Information Statement for the vaccine(s) and understand the risks and benefits. I GIVE CONSENT to the Central District Health Department and its staff for my child named on the front of this form to be vaccinated for ACIP recommended vaccines:

**If this consent form is not signed, dated, and returned, then your child will not be vaccinated**

**Client/Guardian Signature:** \_\_\_\_\_ **Relationship to Child:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**(FOR NURSES USE ONLY)**

**(FOR NURSES USE ONLY)**

**Return Date** \_\_\_\_\_

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

Nurse signature: \_\_\_\_\_



# SPECIAL EVENTS IMMUNIZATIONS

## FINANCIAL POLICY

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 on the Special Events Immunization Consent Form, 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. (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 provide your insurance and/or Medicaid card information on the Special Events Immunization Consent form to enable staff to bill your insurance .
- 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 minimum payments of \$10 per month 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.



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