CENTRAL DISTRICT HEALTH DEPARTMENT

☐ Boise Office 707 N. Armstrong Place, Boise, ID 83704 Phone (208) 327-7450
☐ Mountain Home Office 520 E. 8th N. Street, Mt. Home ID 83647 Phone (208) 587-4407
☐ McCall Office 703 North 1st, McCall ID 83638 Phone (208) 630-8002

To improve the health of our communities by identifying sustainable solutions to community health issues.

CLIENT INFORMATION (PLEASE PRINT) (FLU ONLY)

Last Name: _____ First Name: _____ Middle: _____

Date of Birth: _____ Age: _____ Gender: M or F

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

OPTIONAL

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

Home Phone: _____ Work: _____ Message: _____

Parent or Guardian _____ Mother's Maiden Name_____

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

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

At birth were you a: Single / Twin / Triplet / Other Is the patient on the **WIC** program? ____ Yes ____ No

Medicaid Information

Name (as printed on card):_____Medicaid#_____

Primary Insurance 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:_____

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_____

If left blank, or 0, we will automatically bill at full price.

_____ I understand that childhood immunizations are mandatory but may be refused for medical, religious or philosophical reasons.

_____ 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 _____

SCREENING QUESTIONNAIRE FOR
SEASONAL INFLUENZA VACCINATION

The following questions will help us determine if there is any reason we should not give you or your child a seasonal influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you or your child 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.

Is the patient sick today?	YES	NO	NOT SURE
Does the patient have allergies to medications, food, or any vaccine? (For example: eggs) Please list: _____	YES	NO	NOT SURE
Has the patient ever had a serious reaction after receiving a vaccine? (Routine or Flu vaccines)	YES	NO	NOT SURE
Has the patient ever had Guillain-Barre Syndrome (a type of temporary, severe muscle weakness), seizures or neurological disorders?	YES	NO	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)?	YES	NO	NOT SURE
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	NOT SURE
During the **past year**, 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	NOT SURE
Has the patient received a MMR, Varicella, Rotavirus, or FluMist vaccine in the **past four weeks**? If yes, when: month _____ day _____	YES	NO	NOT SURE
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	NOT SURE
Has the patient had chickenpox? If yes, when? _____	YES	NO	NOT SURE
Does the patient smoke?	YES	NO	NOT SURE
For women: Are you pregnant or is there a chance you could become pregnant during the next month?	YES	NO	NOT SURE

CONSENT

I have read or had explained to me the Vaccine Information Statement for the Seasonal influenza vaccine and understand the risks and benefits. **I GIVE CONSENT** to Central District Health Department and its staff for me or my child named on the front of this form to be vaccinated with this vaccine.

Client/Guardian Signature: _____

Relationship to Client: _____ Date: _____

FOR OFFICE USE ONLY Payment Category: Staff initials: _____

Cash	Credit/Debit Card	Check Number	Insurance	Medicaid	Slide
☐	☐	_____	☐	☐	☐

Date _____

Nurse Signature _____

Return Date _____

(FOR NURSES USE ONLY)