

**PORTAGE COUNTY COMBINED GENERAL HEALTH DISTRICT**

**School Immunization Record**

Information about the person to receive the vaccine(s). Please print.

<b>NAME: Last</b>	<b>First</b>	<b>Birthdate</b>	<b>Sex</b>	<b>Age</b>
<b>ADDRESS:</b>		<b>City</b>	<b>State</b>	<b>Zip</b>
				<b>Phone</b>

**Screening Questions: Which of the following apply to the person receiving the vaccine?**

1. Ill today? .....	<b>Y</b>	<b>N</b>
2. Have allergies to medications, food or any vaccine?.....	<b>Y</b>	<b>N</b>
3. Serious reaction to a vaccine in the past? .....	<b>Y</b>	<b>N</b>
4. Received any other vaccines in the past 28 days? .....	<b>Y</b>	<b>N</b>
5. History of seizures or neurological problems? .....	<b>Y</b>	<b>N</b>
6. History of cancer, leukemia, AIDS, or other immune system problems? .....	<b>Y</b>	<b>N</b>
7. Taken cortisone/prednisone, steroids, or anticancer medications in past 3 months?.....	<b>Y</b>	<b>N</b>
8. Received transfusion of blood or blood products or immunoglobulin in past year?.....	<b>Y</b>	<b>N</b>
9. Pregnant or chance of becoming pregnant in the next month? .....	<b>Y</b>	<b>N</b>

Please explain all of the "yes" replies: \_\_\_\_\_

I have answered the above questions to the best of my knowledge. I have received a copy of the VIS statement about the disease(s) and vaccine(s). I give consent that the vaccine(s) be administered to me or the person for whom I am authorized to make this request. I grant permission for this record to be released to other healthcare providers, health departments, schools, daycare centers, community & state immunization registry databases, and others as permitted by law.

I have read / seen a copy of the HIPPA policy.

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

Signature of Legal Custodian / Client

<b>Please initial "Yes" or "No" for each for the following vaccines:</b>	<b>Yes</b>	<b>No</b>
Hepatitis A		
Human papilloma virus (HPV)		
Meningococcal (ACWY)		
TDaP (tetanus, diptheria, pertussis)		
Varicella (Chickenpox)		
Other _____		

*Please see reverse side*

**PAYMENT**

Private Insurance (Billed by PCHD\*\*) - Circle one:

ID# \_\_\_\_\_

United Health Choice Plus

Medical Mutual

Mutual Health

SummaCare

Aetna

Anthem Blue Cross/Blue Shield

Cigna

Medicaid Insurance (Billed by PCHD) - Circle one:

ID# \_\_\_\_\_

Medicaid

Molina

United Health - Community Plan

Care Source

Buckeye

**No Insurance or a Medicaid Insurance not accepted by PCHD (ex.Paramount, etc.)**

Pay \$10 per vaccine and will be mailed a receipt to submit to insurance company as applicable.

Cash \$ \_\_\_\_\_

Check \$ \_\_\_\_\_

Check # \_\_\_\_\_

\*\*NOTE- if you have an insurance policy not listed above, you have the option of paying for the vaccine(s) at the time of service. You will be given a receipt to submit to the insurance company for reimbursement. Please contact our biller at 330-296-9919, ext. 119 for pricing information and more details. \*\*

**CLINIC/OFFICE USE**

Date Administered	Vaccine	Lot Number	Dosage	Site
				RD / LD
				RD / LD
				RD / LD
				RD / LD
				RD / LD
				RD / LD

Signature of Vaccine Administerer: \_\_\_\_\_ RN