PLEASE PRINT: CHILD FORM (6mos thru 18 years of age) Office Use only: Client ID#_____

Macomb County Health Department Seasonal Influenza Vaccine Program **Today's Date:_____ Time:_____**

Child's Birth date: _____ Child's Sex (Circle One): Male Female

Child's Legal Name: _____
(Last) (First) (Middle)

Race: __White __Asian ___Black/African American ___Multiracial (If multiracial checked, please circle all that apply)

___Native Hawaiian/Pacific Islander __Native Alaskan/American Indian **Ethnicity (Circle if applies)**: Hispanic

Parent/Responsible Party: _____

Street Address: _____

City:_____ State: _____ Zip: _____ County:_____

Telephone #: _____
(Area Code)

Is <u>your child</u> enrolled in any of the following? **____ Medicaid** **____ No Medical Insurance**

____ Commercial Insurance that **<u>does</u>** cover immunizations (circle) **BCBS OF MI BCN HAP MCLAREN PRIORITY OTHER**_____

____ Commercial Insurance that **<u>does not</u>** cover immunizations

THIS SECTION TO BE COMPLETED FOR COMMERCIAL INSURANCES ACCEPTED BY MACOMB COUNTY HEALTH DEPARTMENT:
I authorize any holder of medical information about my child/me to release to commercial insurance or their Intermediaries or carriers, information needed for this claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment below.

Parent/Guardian/Client Signature X_____ Macomb County Health Department Accepts Assignment

Medical Screening Questionnaire and Consent for Vaccination

Please circle the answer to the following questions about you or the person to be vaccinated:

YES NO 1. Ever had a serious reaction to a vaccine?
YES NO 2. Allergic to eggs, Thimerosal, gelatin, or any antibiotics?
YES NO 3. Receive an influenza vaccination during any past flu seasons?
YES NO 4. Ever had Guillain-Barré Syndrome (GBS)?
YES NO 5. Have any long-term health problem such as heart or lung disease, kidney disease or metabolic disease (diabetes)?
YES NO 6. Have severe thrombocytopenia (low platelet count) or a bleeding disorder?
YES NO 7. Currently ill or running a fever?
YES NO 8. Have asthma or have you/your child had a recent episode of wheezing in the past 12 months?
YES NO 9. Currently receiving aspirin therapy?
YES NO 10. Are or may be pregnant?
YES NO 11. Received any vaccine within the past 30 days?
YES NO 12. Have cancer, leukemia, lymphoma, or any immune deficiency disease (inability to fight infection) <u>or</u> currently receiving chemotherapy, radiation therapy or steroid therapy (prednisone or cortisone)?
YES NO 13. Have close contact with anyone who has a severely weakened immune system (for example, an individual who has had a bone marrow transplant and is currently in a hospital isolation room)?

I have read or have had explained to me, the information contained in the Vaccine Information Statement(s) regarding the vaccine(s) to be administered today. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the specific vaccine(s). I ask that the vaccine(s) be given to me, or to the person for whom I am authorized to make this request. I also authorize the Macomb County Health Department to release my immunization record information, or the immunization record information of the person for whom I am authorized to make this request to other health care provider(s) as needed.

Macomb County Health Department Notice of Health Information Practices

I have received a copy of Macomb County Health Department's Notice of Health Information Practices. I understand that my acknowledgement of the Notice is evidenced by my signature on this document. The Department is required to abide by the terms of this privacy notice. The Department may change the terms of its notice at any time. The new notice will be effective for all protected health information that it maintains at that time. Upon my request, the Department will provide me with the revised notice of privacy practices.

X_____ _____
SIGNATURE of Parent/Legal Guardian/ PRINT NAME of Parent/Legal Guardian

_____Received Notice of Health Information Practices **_____REFUSED written acknowledgement** **9-11-17** CHILD

THIS SIDE OF FORM TO BE COMPLETED BY MACOMB COUNTY HEALTH DEPT STAFF ONLY

MCHD OFFICE STAFF USE ONLY **Date of Service:**_____

____ Medicare ____ Self Pay MC (01) _____ Client ID _____

____ Medicaid ____ No Pay (Waived/250) WRN (02) _____ SCS (03) ____ (91/92/93) Facility Zip Code_____

Does client have ___BCBS OF MICHIGAN ___BCN ___HAP ___MCLAREN ___PRIORTY ___OTHER_____

Nurse Staff ID _____ Nurse Confirmation of Client's Birthdate: _____

Vaccine	**Mfg/Lot#**	**Route**	**Site**	**VIS Date**	**VIS Given**
			(circle one)		
FLTQ (IIV4) CP & State (6 MONTHS THRU 35 MONTHS)	_____	IM	RT LT RD LD	08/07/2015	___
FLVQ (IIV4) CP & State (3 YEARS AND OLDER)	_____	IM	RT LT RD LD	08/07/2015	___
FLQ (IIV4) CP (3 YEARS AND OLDER)	_____	IM	RT LT RD LD	08/07/2015	___
FLCX (ccIIV4) CP (4 YEARS AND OLDER)	_____	IM	RT LT RD LD	08/07/2015	___
FLBKQ (RIV3) CP (18 YEARS AND OLDER)	_____	IM	RT LT RD LD	08/07/2015	___

Next Date Due for Immunizations:_____

Progress Notes: _____

Please copy MEDICAID Card/commercial insurance cards.