HENRY COUNTY PUBLIC health

Section 1: Vaccine Recipient Information (Please Print)

Recipient Name: _____
Last First M.I.

Address: _____
Street City State Zip Code

Age:_____ Date of Birth:_____ ☐ Male ☐ Female

Approximate weight (children only): _____ **ALLERGIES:** _____

Would you benefit from calming tools (i.e. weighted lap blanket, cold spray, dimmed lights)? ☐ Yes ☐ No

Section 2: Screening for Vaccine Eligibility (for recipient)

1. Has the patient been acutely ill in the last 24 hours? ☐ Yes ☐ No
2. Is the patient currently taking medication? ☐ Yes ☐ No
   If yes, please list: _____
3. Has the patient ever had a serious reaction to a vaccine? ☐ Yes ☐ No
   What occured: _____
4. Does the patient have cancer, leukemia, lymphoma or receiving drugs which lower the body's resistance to infection? ☐ Yes ☐ No
5. Has the patient had a seizure or a brain problem? ☐ Yes ☐ No
6. Has the patient ever had Guillain-Barre Syndrome? ☐ Yes ☐ No
7. Is the patient American Indian/Alaskan Native? ☐ Yes ☐ No
8. Has the patient received vaccinations in the last 4 weeks? ☐ Yes ☐ No
9. Has the patient received a blood transfusion or been given immune globulin in the past year? ☐ Yes ☐ No
10. Does the patient have a primary care provider (physician)? ☐ Yes ☐ No

Section 3: Insurance Billing ☐ I do not have insurance ☐ My insurance does not cover vaccines

I, the undersigned, certify that the information given by me in applying for payment under the insurance I provided, is correct. I authorize release of all records required to act on their request and request that payment of authorized benefits be made on my behalf or all who may be covered by this insurance. I authorize such insurance to make payment directly to Henry County Public Health.

I also understand that if the insurance DOES NOT pay, I may be billed for today's services.

Insurance Company Name:_____ Insurance #: _____

Policy Holder Name:_____ Date of Birth: _____ Sex: M ☐ F ☐

Signature: _____ **Date:** _____

Phone Number: _____