

CLIENT INFORMATION:

Last: _____ First: _____ MI: _____
Birth Date: _____ SSN(age 18 & over, for internal use only): _____
Address: _____ City: _____ State: _____ Zip Code: _____
Telephone: H (____) _____ Cell (____) _____ Work (____) _____

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Sex: Male Female **Marital Status:** Single Married Widowed
Race: White Asian Black/African Am. Am. Indian Native Hawaiian/Pacific Islander Other
Ethnicity: Hispanic Non-Hispanic

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PARENT/GUARDIAN INFORMATION (if client is under 18):

Last: _____ First: _____ MI: _____
Birth Date: _____ SSN: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Telephone: H (____) _____ Cell (____) _____ Work (____) _____
E-Mail: _____

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For clients age 18 years and under only: Check one below.

- Private insurance KanCare Medicaid No insurance Insurance does not cover immunizations
 Children are school age **and** enrolled in Free or Reduced Lunch Program (proof must be provided).

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Payment or arrangements must be made before the vaccination will be given. How do you plan to pay?

- I will pay full fee for flu or for pneumonia today. Cash or check. Make check out to the Harvey Co Health Dept.
 I wish to apply for a reduced fee. My family's **gross** income is _____ per _____. (Please use your most recent IRS Form 1040 Adjusted Gross Income if you filed taxes.) Number in household: _____.
 Bill private health insurance plan. Insurance card must be presented at time of service.
Policyholder's Name: _____ Policyholder's DOB: _____
 Bill Medicare. Card must be presented at time of service.
 Bill KanCare and/or Medicaid. Insurance card must be presented at time of service.

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Please read and check each box that applies before signing.

- I have been offered the Vaccination Information Statement(s). I have read online (see link) or called the health department to have the information explained to me. (316-283-1637) My questions have been answered satisfactorily. [Vaccination Information Statement\(s\) online](#)
 I request the vaccines to be given to the person named above for whom I am authorized to make this request.
 I acknowledge that I have been offered a copy of Health Department's Notice of Privacy Practices with the effective date of September 12, 2013. [English-Privacy Practices](#) [Spanish-Privacy Practices](#)
 I request payment of insurance benefits to the Harvey County Health Dept.
 I authorize the release of only the medical or billing information necessary to process claims for insurance providers including Medicare or Medicaid.
 I agree to be fully responsible for any co-pay, deductible or non-covered services.

Name of Client or Responsible Party _____ Relationship to Client _____
 Checking here denotes acceptance of an electronic signature. Date _____

For the client to receive vaccines, all questions on the back must be answered.

Does the client have any known allergies to food or medicine? _____YES _____NO
If yes, to what? _____

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FOR THE FLU VACCINE, please answer the following questions:

Has the client received any vaccine within 30 days before today?	NO	YES
Has the client ever received an influenza vaccine?	NO	YES
Has the client ever had a reaction to an influenza vaccination?	NO	YES
Has the client ever had Guillian-Barre syndrome (a form of paralysis)?	NO	YES
Does the client have severe allergy to eggs, egg protein, gentamicin, gelatin or arginine?	NO	YES
Does the client have an allergy to latex?	NO	YES
Does the client have asthma, recurrent wheezing (if under 5), active wheezing?	NO	YES
Is the client receiving aspirin or aspirin-containing treatment (if under 18)?	NO	YES
Does the client have any of the following: kidney disease?	NO	YES
heart disease?	NO	YES
metabolic diseases (e.g. diabetes)?	NO	YES
Any disease that lowers the body's resistance to infection?	NO	YES
Is the client taking steroids or chemotherapy?	NO	YES
Will the client have close contact with anyone who has a weakened immune system and requires care in a protective environment?	NO	YES
Is the client pregnant or nursing?	NO	YES