

NEVADA COUNTY
PUBLIC HEALTH DEPARTMENT
Immunization Record

Complete both sides and Sign back page

<input type="checkbox"/> In County	<input type="checkbox"/> Out of County	<input type="checkbox"/> UNINSURED
<input type="checkbox"/> Straight Medi-Cal		<input type="checkbox"/> CASH \$ _____
<input type="checkbox"/> Partnership		<input type="checkbox"/> CHECK # _____
<input type="checkbox"/> Blue Shield EPO/PPO		<input type="checkbox"/> CREDIT CARD
		<input type="checkbox"/> VOUCHER

PATIENT
DOB _____ AGE ____ Yrs ____ Mos GENDER _____ Mother's First Name _____
MM / DD / YY
PATIENT NAME _____ Parent/Guardian Name _____
ADDRESS _____ CITY _____ ZIP _____

Preferred method for Appointment Reminders/Notifications: Call Text
Home Phone: _____ Call / Leave a message Yes No
Cell Phone: _____ Call / Leave a message Yes No

Our clinic now offers you the opportunity to use the web to track aspects of your health care through our online Client Portal. Using a secure username and password, clients can view health information such as upcoming appointments, medications, immunizations, allergies, and lab results. Your Client Portal Account will be linked to one unique email address. Please provide us with an email address that only you have access to so that we can set up your Client Portal Account.

Email: _____ Primary Care Physician: _____

Nevada County Public Health Department requires that we collect the following demographic data. This information is confidential and allows us to provide quality services. **THE INFORMATION BELOW IS FOR THE INDIVIDUAL RECEIVING IMMUNIZATION(S).**

Race		Ethnic Group	Language
<input type="checkbox"/> Alaska Native or American Indian	<input type="checkbox"/> White or Hispanic	<input type="checkbox"/> Hispanic	<input type="checkbox"/> English
<input type="checkbox"/> Asian	<input type="checkbox"/> More than One Race	<input type="checkbox"/> Non-Hispanic	<input type="checkbox"/> Spanish
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Other Race	<input type="checkbox"/> Unknown	<input type="checkbox"/> Indian (includes Hindi & Tamil)
<input type="checkbox"/> Native Hawaiian or Pacific Islander	<input type="checkbox"/> Declined to State		<input type="checkbox"/> Other

VFC Eligibility (Children 18 years and under)

The following statements will help us determine if your child may receive immunizations through the Vaccine for Children (VFC) program.

Please check applicable box below for child receiving immunization:

- 1. is Medi-Cal or Child Health & Disability Program (CHDP) eligible.
- 2. is Uninsured (does not have private health insurance).
- 3. is an American Indian or Alaskan Native.

317 Eligibility (Adults 19 years and over)

The following statements will help us determine if you may receive immunizations through the State 317 program.

Please check applicable box below for person receiving immunization:

- 1. is Uninsured (does not have private health insurance, Medi-Cal or Medi-Cal Managed Care).
- 2. is Underinsured, patient has health insurance, but it
 - Doesn't cover vaccines, or
 - Doesn't cover certain vaccines

We currently accept Medi-Cal and Blue Shield insurance. If you do not have either of these insurance plans, we accept cash, check, or credit cards (VISA/MasterCard/Discover) for payment. There is an additional \$2.00 processing fee for using a credit card. I understand that my health insurance will be billed as a courtesy and I am responsible for payment of any charges unpaid by my insurance.

- Medi-Cal, including Medi-Cal Managed Care
- Blue Shield PPO / EPO (**Vaccine supplies are limited**)
- I do not have health insurance
- Health Insurance number _____

Medicare Non-Participation Policy Agreement

Nevada County Public Health does not bill Medicare for any services. "The Medicare Benefit Policy Manual, Publication 100-02, Chapter 15, Section 40.5 states that when a physician/practitioner opts out of Medicare, Medicare covers no services provided by that individual and no Medicare payment can be made to that physician or practitioner directly or on a capitated basis. Additionally, no Medicare payment may be made to a beneficiary for items or services provided directly by a physician or practitioner who has opted out of the program".

Please read and sign the following:

I acknowledge that I have received or have been offered a copy of the Nevada County Notice of Privacy Practices. I have been given a copy and have read or have had explained to me the information contained in the Vaccine Information Statement(s) about the disease(s) and the vaccine(s) indicated. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) indicated to be given to me or the person named above for whom I am authorized to make this request. I understand that Nevada County Public Health Department enters immunization information into the California Immunization Registry (CAIR). I hereby authorize the Nevada County Public Health Department, to release this information to my healthcare provider(s), school(s) and insurance provider.

NEVADA COUNTY PUBLIC HEALTH DEPARTMENT

Yes No

Is client sick today? Is client taking antibiotics?

Does client have allergies to medications, food, a vaccine ingredient, or latex?

Any serious reactions to other Immunizations?

Does client have a long-term health problem with heart, lung, kidney, or metabolic disease, asthma, blood clotting disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak?

Does client or anyone in their household have Cancer, Leukemia, HIV/AIDS, or other immune system problems?

In the past 3 months, has client taken medicines that affect their immune system such as prednisone, steroids, or anti-cancer meds: drugs for the treatment of rheumatoid arthritis, Crohn's Disease, psoriasis, or X-ray/radiation treatment?

Yes No

Has client had a seizure, brain or other nervous system problem?

During the past year has client received transfusion of blood/blood products, or been given immune (gamma) globulin or antiviral drug?

Is client pregnant or a chance client could become pregnant in the next month?

Is client breast-feeding?

Has client had any vaccinations in the past 4 Weeks? What kind? _____

If client is 2-4 years old, has health care Provider diagnosed wheezing or asthma in the Past 12 months?

If client is a baby, has there been a diagnosis of Intussusception?

Have you had chicken pox?

Have you had a Tdap booster?

Print Name (Parent/Guardian/Self) **Signature** (Parent/Guardian/Self) **Date**

Public Health Use Only

VFC STATE 317 County Purchased (PP)

Immunization Given	Lot #	VIS Date
LASq LD LT RASq RD RT PO	Exp. Date	
		<input type="text"/>

Immunization Given	Lot #	VIS Date
LASq LD LT RASq RD RT PO	Exp. Date	
		<input type="text"/>

Immunization Given	Lot #	VIS Date
LASq LD LT RASq RD RT PO	Exp. Date	
		<input type="text"/>

VFC STATE 317 County Purchased (PP)

Immunization Given	Lot #	VIS Date
LASq LD LT RASq RD RT PO	Exp. Date	
		<input type="text"/>

Immunization Given	Lot #	VIS Date
LASq LD LT RASq RD RT PO	Exp. Date	
		<input type="text"/>

Immunization Given	Lot #	VIS Date
LASq LD LT RASq RD RT PO	Exp. Date	
		<input type="text"/>

Vaccine Not Given

VIS Sheet(s) Given

Reason why: _____

Date: _____

RN Signature _____

Initial: _____