SALT LAKE COUNTY HEALTH DEPARTMENT

School Encounter Form

No charge Flu Vaccine

Please check one:

☐Private Insurance: Injection Only (Flu Mist not available due to grant limitations)

☐ Medicaid ☐ Non-Insured ☐ CHIP ☐ American Indian/Alaska Native

Parental preference: Flu Mist ☐ Injection ☐

There are a limited number of Flu Mist administrations.

Yes ☐ No ☐ **If Flu mist is unavailable, my student may receive an injection.**

First Name:	Last Name:	Middle Name:
Date of Birth:	Sex: Male ☐ Female ☐	Race:	Ethnicity: Hispanic or Latino ☐ Not Hispanic or Latino ☐
Address:	Apartment:	City:
State:	Zip Code:	Home Phone:	Cell Phone:
Parent's Name:		

1. Are you well today? **Y** or **N**
2. Have you had any immunization in the last month? **Y** or **N** Type:_____
3. Any problems with previous vaccines/fainting? **Y** or **N**
4. Have you had blood products in the past 6-11 months? **Y** or **N**
5. Are you on aspirin therapy? **Y** or **N**
6. Any problems with your immune system? **Y** or **N**
7. Female more than 9 yrs of age? Could you be pregnant? **Y** or **N**
8. Have you had history of chicken pox? **Y** or **N**

STOP! SCHOOL USE ONLY BELOW

✓	Vaccine	Lot #	Site #	CPT	ICD10	Dose	Route
	DTap (1-5) < 7 yrs			90700	Z23	0.5cc	IM
	Hepatitis A > 1 yr			90633	Z23	0.5cc	IM
	Hepatitis B (1–3) < 19 yrs			90744	Z23	0.5cc	IM
	9vHPV 11–26 yrs			90651	Z23	0.5cc	IM
	IPV (1–4+)			90713	Z23	0.5cc	IM/SQ
	Menig MCV4 ≥ 9 mo			90734	Z23	0.5cc	IM
	MMR > 1 yr			90707	Z23	0.5cc	SQ
	Td (1–3) > 7 yrs			90714	Z23	0.5cc	IM
	Tdap > 7 yrs (Adacel)			90715	Z23	0.5cc	IM
	Varicella > 1 yr			90716	Z23	0.5cc	SQ
	Pres Free Quad Flu			90686	Z23	0.5cc	IM
	Multi Dose Quad Flu			90688	Z23	0.5cc	IM
	Flu Mist 2-49 yrs			90672	Z23	0.5cc	IN

Provider Name: _____

Provider Signature:_____ ***Date:***_____/_____/_____

Office Use Only

Client PID Number:_____ **Date:**__/_____/_____

Registered: Employee Name_____

Close Out: Employee Signature_____

SALT LAKE COUNTY HEALTH DEPARTMENT

Conditions of Treatment

Please read and initial each item below:

_____ **Consent for Treatment**
I have received a copy and have read, or had explained to me, the information contained in the Vaccine Information Statement(s) about the vaccine(s) I have requested or have been recommended to me, their risks, and about the disease(s) that the vaccine(s) protect against. I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) indicated in the Vaccine Information Statement(s) stated above be given to me or to the person for whom I am authorized to make this request. I certify that these statements are true and accurate.

_____ **Insurance Coverage**
Applies only if billing Medicaid, Medicare, and/or a Salt Lake County Health Department-contracted insurance

I understand that my health insurance coverage may have certain restrictions and limitations. I agree to pay the full amount for any and all related charges, if they are not covered by my insurance. If I fail to pay for these services and charges within sixty (60) days of receiving notice that the charges are not covered for any reason, my account will be turned over to collections. In the event my account is turned over to collections, I agree to pay attorney fees and collection charges which may apply. I hereby request and authorize the Salt Lake County Health Department to submit claims to my Medicaid, Medicare and/or Health Department-contracted insurance.

_____ **Privacy Rights**
I have been provided and have had the opportunity to read Salt Lake County Health Department's Notice of Privacy Practices. Furthermore, any questions I had regarding the policy have been explained to me by the Health Department staff. In addition, I understand that I may request a copy of these practices in a reasonable alternative format. I agree that this information may be shared with health care providers, health care personnel, public health personnel and other health care professionals who have a legitimate need to access the immunization information to: verify immunization status; audits; conduct public health studies; and assist a patient or to protect the health of individuals closely associated with the patient. I understand that I have the right to revoke this authorization at any time by notifying the Salt Lake County Health Department in writing. This release of information will be effective until canceled in writing. I understand that once my data is shared with another individual or agency, it may lose the protections provided by the HIPAA Privacy Rule, and may be re-disclosed by that recipient.

Indicate relationship to the person receiving services:

☐ Self ☐ Parent ☐ Sibling (over 18) ☐ Grandparent

☐ Guardian ☐ Other: _____

If under 18 years of age:

I am a:

☐ Pregnant Minor ☐ Married Minor ☐ Homeless Teen

By signing, you indicate that you have read, understand, and agree to these terms; that you have received a copy of this document; and that you are the patient, guarantor, the patient's legal representative, or legally authorized to sign this agreement and accept these terms.

Patient Name (please print): _____

Your Name (please print): _____

Signature: _____ Date: _____