THE CITY OF COLUMBUS
ANDREW J. GINTHER, MAYOR
COLUMBUS PUBLIC HEALTH

# *Immunization Form*

**Last Name**_____ **First Name**_____ **MI** ____
**Date of Birth (MM / DD /YYYY)** ____ / ____ / _____ **Age** _____ **Sex:** ☐ **Male** ☐ **Female**
**Address**_____ **Apt #**_____
**City**_____ **State**_____ **ZIP Code**_____ **Home Phone** (____) _____ - _____
**Cell phone** (____) _____ - _____ **Social Security Number** _____
**Ethnicity:** ☐Hispanic ☐Non-Hispanic **Race:** ☐Amer. Indian / AK Native ☐Asian ☐Black/African Amer. ☐Native HI/Pacific Island ☐ White ☐Other
**Smoking:** Are you a smoker? ☐ Yes ☐No Do you live with anyone who is a smoker ☐ Yes ☐ No
**Preferred Language** _____ **Marital Status**_____ **Highest level of Education** _____

| **Please answer all questions.** | **Yes** | **No** | **Don't Know** |
|---|---|---|---|
| 1. Is the client prone to fainting or light-headedness with shots or blood draws? | ☐ | ☐ | ☐ |
| 2. Is the client sick today? | ☐ | ☐ | ☐ |
| 3. Does the client have allergies to egg, latex, medications, food, or any vaccine or vaccine component (Including polymycin, neomycin, gentamicin, or gelatin)? | ☐ | ☐ | ☐ |
| 4. Has the client had a serious reaction after receiving a vaccine in the past? | ☐ | ☐ | ☐ |
| 5. Has the client had a health problem with lung, heart, kidney, liver or metabolic disease (e.g., diabetes), anemia, or a blood disorder? Is he/she on long-term aspirin therapy? | ☐ | ☐ | ☐ |
| 6. If the client is between the ages 2 and 4 years old, has a healthcare provider told you that the client had wheezing or asthma in the past 12 months? | ☐ | ☐ | ☐ |
| 7. If the client is a baby, have you ever been told he or she has had intussusception? | ☐ | ☐ | ☐ |
| 8. Has the client, a sibling, or a parent had a seizure; has the client had brain or other neurological disease? Has the client ever had Guillain-Barré syndrome? | ☐ | ☐ | ☐ |
| 9. Does the client have cancer, leukemia, HIV/AIDS, or any other immune system problem? | ☐ | ☐ | ☐ |
| 10. In the past 3 months, has the client taken medications that weaken the immune system such as cortisone, prednisone, other steroids, anticancer drugs, or had radiation treatments? | ☐ | ☐ | ☐ |
| 11. In the past year, has the client received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug (e.g., amantadine(Symmetrell), rimantadine(Flumadine), zanamivir(Relanza), oseltamivir(Tamiflu)? | ☐ | ☐ | ☐ |
| 12. Does the client to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (e.g., an isolation room of a bone marrow transplant unit)? | ☐ | ☐ | ☐ |
| 13. Is the client pregnant or is there a chance she could become pregnant during the next month?<br>14. Date of Last Menstural Cycle? | ☐ | ☐ | ☐ |
| 15. Has the client received any other vaccinations in the past 4 weeks? | ☐ | ☐ | ☐ |

**Insurance Information:** ☐ Care Source ☐ Molina ☐ Medicaid ☐ Other _____
Information from insurance card: Policy number _____
Phone number_____Claims address on insurance _____
☐ **I do not have health insurance.** Household income _____ Number in Household_____
For Coalition vaccine: My income is $21,774 or less for individual or $29,470.50 or less for a household (less than 185% poverty level.) I am unable to pay for services rendered (sign here for hardship waiver.)_____

**Consent**
1. I give permission for Columbus Public Health staff and/or physicians to provide all services as may be necessary to diagnose and/or treat the above mentioned client. 2. I understand I may request a clinical chaperone (third person) to be present during the exam. 3. I also understand that any care received outside Columbus Public Health (e.g., x-rays, specialist care) will not be paid for by Columbus Public Health. 4. I authorize the release of medical information necessary to process this claim for billing. I agree to pay my co-pay and for any charges not covered by insurance or grants. 5. I verify that the information I have given here is true to the best of my knowledge. 6. I verify that I have reviewed and confirmed my client information. 7. Privacy Notice Statements: I have received a copy of the Privacy Notice today or at my first visit to Columbus Public Health.

**Client Signature:**_____ **Date:**_____

**Staff Signature:**_____ **Date:**_____

Reminder/Recall_____ - **This side to be filled out by nursing staff** - NG encounter#_____

**Patient Name: LAST:** **FIRST:** **DOB:**

**VFC:** ☐Mcd ☐NoIns ☐Underins ☐AKAN ☐Inelig **Clinic:** ☐Worth ☐Hanna ☐Flu ☐ESL ☐PL ☐Schools ☐_____ **Triage RN:**____

| CPT | # | VACCINE | ICD-10 | Admin Fee | ODH | COALITION | PRIVATE CHARGE |
|---|---|---|---|---|---|---|---|
| 90685 | | Flu IIV4 6-35months | Z23 | $21.00 | | | $27.00 |
| 90686 | | Flu IIV4 3+ yrs | Z23 | $21.00 | NC | NC | |
| 90672 | | Flumist Child 2-49 yrs | Z23 | $21.00 | NC | NC | $30.00 |
| 90662 | | Flu High Dose 65+ yrs | Z23 | | NC | NC | $40.00 |
| 90633 | | HAV Child 1-18 yrs | Z23 | $21.00 | NC | | $68.00 |
| 90632 | | HAV Adult 19+ yrs | Z23 | | NC | | $56.00 |
| 90744 | | HBV ped/adol 0-19 yrs | Z23 | $21.00 | NC | | $25.00 |
| 90746 | | HBV Adult 20+ | Z23 | | NC | | $66.00 |
| 90648 | | HIB < 5 | Z23 | $21.00 | | | $31.00 |
| 90651 | | HPV 9 11-26 yrs | Z23 | $21.00 | NC | | $191.00 |
| 90732 | | PPV23 | Z23 | | NC | | $91.00 |
| 90734 | | MCV4 11-55 yrs | Z23 | $21.00 | NC | | $127.00 |
| 90707 | | MMR 1+ yrs | Z23 | $21.00 | NC | | $64.00 |
| 90710 | | MMRV 2-12 yrs | Z23 | $21.00 | NC | | $173.00 |
| 90670 | | PCV13 Prevnar | Z23 | $21.00 | NC | | $190.00 |
| 90713 | | Polio <18 yrs | Z23 | $21.00 | | | $30.00 |
| 90680 | | Rota 3-dose 2-32 months | Z23 | $21.00 | | | $80.00 |
| 90723 | | Pediarix (DTaP-Hep B-IPV) < 7 yrs | Z23 | $21.00 | | | $75.00 |
| 90698 | | Pentacel (DTAP-HIB-IP)< 5 yrs | Z23 | $21.00 | | | |
| 90700 | | DTaP < 7 yrs | Z23 | $21.00 | | | $30.00 |
| 90714 | | Td 7+yrs | Z23 | $21.00 | NC | | $25.00 |
| 90715 | | Tdap | Z23 | $21.00 | NC | | $34.00 |
| 90716 | | Varicella | Z23 | $21.00 | NC | | $114.00 |
| 90696 | | Kinrix 5thDTP/4thIPV 4-6 | Z23 | $21.00 | | | |
| 90696 | | Quadracel | Z23 | $21.00 | | | |
| 90620 | | Men B | Z23 | $21.00 | NC | | |
| 90636 | | Twinrix (HBV/HAV) | Z23 | | NC | | |
| 90736 | | Zostavax | Z23 | | NC | | $232.00 |
| 99211 | | Office Assessment | Z41.8 | $16.00 | NC | | $16.00 |

**Hardship Waiver: _____ Income_____ Family Size_____Today's Charge: Pay/Adj:**

| Vaccine | Seq# | Rte | Site | Lot | Exp date | |
|---|---|---|---|---|---|---|
| Flu | | IM | L R Deltoid VLat | | | |
| Hep A | | IM | L R Deltoid VLat | | | |
| Hep B | | IM | L R Deltoid VLat | | | |
| Twinrix | | IM | L R Deltoid VLat | | | |
| Hib | | IM | L R Deltoid VLat | | | |
| HPV | | IM | L R Deltoid VLat | | | |
| MCV4 MENACTRA | | IM | L R Deltoid VLat | | | |
| MMR | | SQ | L R Arm Thigh | | | |
| MMRV Proquad | | SQ | L R Arm Thigh | | | |
| PCV13 | | IM | L R Deltoid VLat | | | |
| PPV23 | | SQ | L R Arm Thigh | | | |
| Polio | | SQ | L R Arm Thigh | | | |
| Rota | | Oral | | | | |
| DHI Pediarix | | IM | L R Deltoid VLat | | | |
| Pentacel | | IM | L R Deltoid VLat | | | |
| DTaP | | IM | L R Deltoid VLat | | | |
| Td | | IM | L R Deltoid VLat | | | |
| Tdap | | IM | L R Deltoid VLat | | | |
| VAR | | SQ | L R Arm Thigh | | | |
| Kinrix or Quadracel | | IM | L R Deltoid VLat | | | |

Admin RN Signature_____ Date_____

WIC ☐ Yes ☐ inelig ☐ Ref