School Immunization 2023

Today's Date____________________________

Client Name____ Date of Birth____________________

Mailing Address____________________________________ Current school____________________________

City___________________________ State________ Zip Code___________ Phone_(____)_________________

Parents___________________________________ Mother's Maiden Name_____________________________

Is the individual Hispanic or Latino? YES NO Gender: Male Female

Race: White American Indian more than one race other/unknown

Are You Military? Please circle one- Veteran Active Duty Family Member

<u>If you have insurance please call them to verify immunization coverage prior to completing this form –Thank You.</u> RCHD is not responsible to inform you of what your insurance will or will not cover. You will be responsible for any balance.

<u>Determining VFC</u>

Do you have health insurance that covers vaccines Yes or No

*Name of insurance:____

*Name of cardholder:____

Do you qualify for IHS (Indian Health Service) Yes or No

Or other federally funded insurance

Is your child enrolled in Healthy Montana Kids Plus (Medicaid) Yes or No

For office use only
PAYMENT
CASH________________________
CHECK#______________________
EMPLOYER____________________

<u>Cost & Method of Payment</u>

If you <u>do not</u> have insurance or you qualify for IHS or your insurance does not cover vaccines; your child maybe eligible for Vaccines For Children Program, please ask.

<u>Please photocopy front and back of insurance card and bring with form</u>

TDaP	HeptA	Meningococcal	HPV	Influenza
$65.00	$55.00 per vaccine	$165.00	$280.00 per vaccine	$ 45.00

Please make payment to **RICHLAND COUNTY HEALTH DEPARTMENT OR RCHD

I give permission for Richland County Health Department to enter my or my child's vaccine information into the electronic statewide immunization registry. This information will only be shared with health care providers and schools as necessary.

Client or Parent Signature____Date_______________

Richland County Health Department
1201 West Holly Suite #1
Sidney MT, 59270
406-433-2207

Please fill out reverse side

For Nurses Only

VFC
PRIVATE

Form Reviewed/Vaccinator Signature & Date:____________________________________

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Screening Checklist for Contraindications

Client Name: ___________________________________

Date of Birth: _______/________/__________

The following questions will help us determine if the vaccinations may be given to you or your child today. If you answer "yes" to any question, it does not necessarily mean you or your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't Know
1. Is client sick today?			
2. Does client have allergies to a vaccine component or to latex?			
3. Has client had a serious reaction to a vaccine in the past?			
4. Has client had brain or other nervous system problems?			
5. For Females: Is client pregnant?			

Form completed by: ____Date:_________________

Form reviewed by: ____Date: _________________

Did you bring your immunization record card with you? Yes No

It is important to have a personal record of vaccinations received. If you don't have one, ask your healthcare provider to give you one with all your vaccinations on it. Keep it in a safe place and make sure to carry it if you seek medical care. You will likely need this document to enter school or college, for employment, or for international travel.

Technical content reviewed by the Centers for Disease Control and Prevention

Saint Paul, Minnesota · 651-647-9009 · www.immunize.org · www.vaccineinformation.org

www.immunize.org/catg.d/p4062.pdf