In partnership with McCrary Rost Clinic, Calhoun County Public Health will be providing necessary immunizations in coordination with athletic physicals. Student athletes will be screened for necessary adolescent/ teen immunizations; Parents please fill out and sign form. Students should bring this form with them to their physical. All student athletes should bring insurance information with them, cost of vaccines will be billed to individual insurance companies.

Calhoun County Public Health
Screening Checklist for Immunization

PLEASE PRINT CLEARLY

Gender: (circle) M F

Client's Name: _____ Birthdate: ____/____/____
First Name Last Name MI

Address: _____ Phone: _____
Street City Zip Code

Doctor's Name: _____

Parent/Guardian/Individual of Record: _____
First Name Last Name MI

Indicate eligibility status (check only one):

☐ Is Enrolled in Medicaid: Medicaid #_____

☐ DOES NOT have health insurance

☐ Is American Indian or Alaskan Native (AI/AN)

☐ Is underinsured because health insurance DOES NOT pay for vaccines (Underinsured includes those with health insurance but plan does not include vaccines, covers only select vaccines, or caps the vaccine cost at an established unit)

☐ Is NOT ELIGIBLE for the VFC PROGRAM because above criteria not met.

☐ Has private insurance. Who with? _____ #:_____ Policy Holder: _____

1. Have you / your child been sick in the last 48 hours? ____Yes ____No
   Temperature _____
2. Do you / your child have any allergies? ____Yes ____No
3. Have you / your child had a serious reaction to a vaccine in the past? ____Yes ____No
4. Have you / your child had a health problem with lung, heart, kidney or metabolic disease - Ex: diabetes, asthma or a blood disorder? ____Yes ____No
5. Have you / your child, sibling, or parent had a history of seizures? ____Yes ____No
6. Females only: Are you / your child / teen pregnant or is there any chance you / she could become pregnant in the next month? ____Yes ____No
7. Have you / your child been vaccinated in the past 4 weeks ____Yes ____No

Comments:_____

_____

By signing below:

- I authorize Calhoun County to bill my insurance $_____. **I know I am responsible for any balance remaining if my insurance denies any part of the bill.**
- I have read and understand the appropriate Vaccine Information Statement (s).
- I have had a chance to ask questions which were answered to my satisfaction.
- I understand the benefits and risk of the vaccines (s) and ask that the vaccine be given to me, or to the person's name for whom I am authorized to make this request.
- I accept responsibility for seeking medical attention for any problems with this vaccination.

_____

Signature of person to receive vaccine (18 years or older) or Parent/Guardian Date

_____ ____/____/____

Staff Signature Date

Client's Name _____ Date of Service_____
Staff Signature _____ Initial_____
Staff Signature _____ Initial_____

IRIS Completed on_____ Staff Initial_____

Billing Completed on_____ Staff Initial_____

Vaccine	Lot #	Inj Site	Adm By	VIS Version Date	Vaccine	Lot #	Inj Site	Adm By	VIS Version Date
Dtap				5-17-07	Hib (PRP-T)				12-16-98
Dtap/IPV (Kinrix)				11-16-12	HPV, quadrivalent (Gardasil)				5-17-13
Dtap, IPV, Hep B (Pediarix)				11-16-12	IPV				11-08-11
Dtap, IPV, HIB (Pentacel)				11-16-12	Meningococcal (Menactra/MCV4)				10-14-11
Influenza 6mo-to 35mo				8-07-15	MMR				4-20-12
Influenza 3yrs & older				8-07-15	MMRV (varicella - Proquad)				11-16-12
Influenza, live, intranasal				8-07-15	Pneumococcal conjugate PCV13				2-27-13
Hep A – ped/adol 2 dose				10-25-11	Pneumococcal poly PPV23 (adult)				10-6-09
Hep A – Adult				10-25-11	Rotavirus, pentavalent (Rotateq ORAL)				12-06-10
Hep B – ped/adol				2-02-12	Tdap				5-09-13
Hib - Hep B (Comvax)				11-16-12	Varicella				3-13-08
Hep B – Adult				2-02-12	Zoster				10-06-09