Children/Teen Immunizations

Registered: _____
Scanned: _____
EZ Imm Doc: _____
ICARE: _____

Last Name_____ First_____ MI _____

Date of Birth _____/_____/_____ Age _____ Male Female Other

Street Address _____ Phone _____

City _____ Zip _____ PID/MRN _____

Self-Pay
Medicaid
Private INS

Select	Vaccine	Lot#	Site	Nurse Date/Time	Price
	DTaP				$45.00
	Hep A				$50.00
	Hep B				$40.00
	Hib				$40.00
	HPV				$295.00
	Kinrix (DTaP + IPV)				$70.00
	Meningococcal				$170.00
	Meningococcal B				$240.00
	MMR II				$105.00
	Pediarix (DTap + IPV+HepB)				$110.00
	Pneumococcal 13				$265.00
	Polio (IPV)				$50.00
	Proquad (MMR V)				$295.00
	Rotavirus				$110.00
	TD (special order only)				$50.00
	TdaP				$60.00
	Varicella				$180.00
	Influenza				$35.00
	COVID:				
	Pfizer **6mo-4yr** 1 2 3				n/a
	Moderna **6mo-5yrs** 1 2 3*				n/a
	Moderna **6-11yrs** 1 2 3*				n/a
	Moderna **12-17yrs** 1 2 3*				n/a
	Pfizer **5-11yrs** 1 2 3*				n/a
	Pfizer **12 -17yrs** 1 2 3*				n/a
	Novavax **12-17yrs** 1 2				n/a
	Pfizer Bivalent Booster **5 -11y**				n/a
	Pfizer Bivalent Booster **12 & Up**				n/a
	Moderna Bivalent Booster **6 – 11yrs**				n/a
	Moderna Bivalent Booster **12 & Up**				n/a

*For immunocompromised individuals only

MEDICAID: RECIPIENT ID#_____MCO: _____

NO INSURANCE/UNDERINSURED/ AMERICAN INDIAN/ALASKIAN NATIVE: **VFC** (TITLE 19) **CHIP** (TITLE 21)

PRIVATE INSURANCE: _____

PRIMARY INS. NAME: _____ DOB_____/____/_____ **PRIVATE**

MEMBER ID#: _____

For parents/guardians: The following questions will help us determine which vaccines your child may be given today. If you answer "yes" to any question, it does not necessarily mean 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.

Screening Questions	Yes	No	Unsure
Is the child sick today?			
Does the child have allergies to medications, food, a vaccine component, or latex? Describe:			
Has the child had a serious reaction to a vaccine in the past? Describe:			
Does the child have a long-term health problem with lung, heart, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Is he/she on long-term aspirin therapy? Describe:			
If the child to be vaccinated is 2 through 4 years of age, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?			
If your child is a baby, have you ever been told he or she has had intussusception?			
Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?			
Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem? Describe:			
Does the child have a parent, brother, or sister with an immune system problem?			
In the past 3 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments? Describe:			
In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?			
Is the child/teen pregnant or is there a chance she could become pregnant during the next month?			
Has the child received vaccinations in the past 4 weeks?			
Has the child ever had Guillain-Barre Syndrome?			

- ☐ **I would like information on the WIC nutritional supplement program, or other services available at the Health Department**
- ☐ **I would like to speak to someone regarding a financial assistance program for immunization costs**

I believe I understand the benefits, the risks of the vaccine(s) and ask the vaccine(s) stated above be given to me or the person above who I am authorized to make this request.
I understand that the HD is authorized to use the information gained during treatment to bill me or any other potential sources of reimbursement, such as government programs in which I am enrolled or qualified for services. Also, by signing I acknowledge that I am responsible for any remaining balance or co-pays that the provided insurance does not cover.

Signature: _____ Date: _____

_____ _____

Printed Name if not the patient Relationship to the patient