Nurse—White Copy
Client –Pink Copy

Logan County Department of Public Health Immunization Intake Form

PLEASE COMPLETE ENTIRE FORM FOR PERSON TO RECEIVE IMMUNIZATIONS

*Information about the person to receive vaccine (**Please Print**):* Date:

First Name:	Middle Name:	Last Name:	Maiden Last Name:
Birth Date(DOB): / Age:	Sex: M F	County of Birth:	Has person received any vaccinations under a different last name? If Yes, enter name:
Parent/Guardian: First: Last:			Is child in foster care?
Phone Number: ( )	Street Address:		
City:	State:	Zip:	

Person being immunized: Circle Number
1. Has Medicaid/Medicaid managed care
2. Not Insured/No Insurance
3. American Indian/Alaskan Native
4. Insurance does not cover immunizations
5. Insurance covers immunizations

Name of Doctor and address:

Medical Information about the person to receive vaccine:

Please answer each question by checking (X) in appropriate box	Yes	No	Don't Know
Is the person being immunized sick today?			
Does the person being immunized have allergies to medications, food, or any vaccine (in particular neomycin, yeast, bread, gelatin, thimerosol, eggs, polymyxin B, streptomycin)?			
Has the person being immunized ever had a problem after any vaccine such as fever greater than 104 degrees, a high pitched cry, screaming for more than 3 hours, a rash, or any other type of reaction?			
Has the person being immunized had a fever in the last 24 hours? Temperature reading_____			
Does the person being immunized have cancer, leukemia, AIDS, or any other immune system problem?			
Has the person being immunized or any person living with the recipient taken cortisone, prednisone, other steroids, or anticancer drugs, or radiation treatments?			
Has the person being immunized received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin in the past year?			
Is the person being immunized pregnant or is there a chance she could become pregnant during the Next 3 months? If pregnant, is the recipient breast feeding?			
Has the recipient had a shot within the last 30 days?			
Does the person being immunized have an altered immune system, chronic gastrointestinal disease, or a history of bowel intussception?			
Is the person being immunized going to have a tuberculosis skin test in the next 30 days?			
Has the person being immunized ever had seizures or other neurologic problems?			

I hereby affirm that I am the person that I represent myself to be and that I stand in the relationship to the client as I have indicated.
Signature of the person to receive vaccine or person authorized to make the request (parent or guardian):

Signiture_____Relationship to Child:_____Date:_____