PORTAGE COUNTY COMBINED GENERAL HEALTH DISTRICT

School Immunization Record

Information about the person to receive the vaccine(s). Please print.

NAME: Last	First	Birthdate	Sex	Age

ADDRESS:	City	State	Zip	Phone

Screening Questions: Which of the following apply to the person receiving the vaccine?

1. Ill today? ……..	**Y**	**N**
2. Have allergies to medications, food or any vaccine?.....	**Y**	**N**
3. Serious reaction to a vaccine in the past? ……..	**Y**	**N**
4. Received any other vaccines in the past 28 days? ……..	**Y**	**N**
5. History of seizures or neurological problems? ……..	**Y**	**N**
6. History of cancer, leukemia, AIDS, or other immune system problems? ……..	**Y**	**N**
7. Taken cortisone/prednisone, steroids, or anticancer medications in past 3 months?.....	**Y**	**N**
8. Received transfusion of blood or blood products or immunoglobulin in past year?.....	**Y**	**N**
9. Pregnant or chance of becoming pregnant in the next month? ……..	**Y**	**N**

Please explain all of the "yes" replies: _____

_____

_____

_____

I have answered the above questions to the best of my knowledge. I have received a copy of the VIS statements about the disease(s) and vaccine(s). I give consent that the vaccine(s) be administered to me or the person for whom I am authorized to make this request. I grant permission for this record to be released to other healthcare providers, health departments, schools, daycare centers, community & state immunization registry databases, and others as permitted by law.

I have read / seen a copy of the HIPPA policy.

X _____ Date: _____

Signature of Legal Custodian / Client

Please initial "Yes" or "No" for each for the following vaccines:	Yes	No
Hepatitis A		
Human papilloma virus (HPV)		
Meningococcal (ACWY)		
TDaP (tetanus, diptheria, pertussis)		
Varicella (Chickenpox)		
Other _____		

Please see reverse side

Portage County Combined General Health District
705 Oakwood St., Ravenna, OH 44266

PAYMENT

Private Insurance (Billed by PCHD) - Circle one:** **ID#** _____

United Health Choice Plus **Medical Mutual** **Mutual Health** **SummaCare**

Aetna **Anthem Blue Cross/Blue Shield** **Cigna**

Medicaid Insurance (Billed by PCHD) - Circle one: **ID#** _____

Medicaid **United Health - Community Plan** **Care Source** **Buckeye**

No Insurance or a Medicaid Insurance not accepted by PCHD (ex. Molina, Paramount, etc.)
Pay $10 per vaccine and will be mailed a receipt to submit to insurance company as applicable.

Cash $_____ **Check $**_____ **Check #**_____

**NOTE- if you have an insurance policy not listed above, you have the option of paying for the vaccine(s) at the time of service. You will be given a receipt to submit to the insurance company for reimbursement. Please contact our biller at 330-296-9919, ext. 119 for pricing information and more details. **

CLINIC/OFFICE USE

Date Administered	Vaccine	Lot Number	Dosage	Site RD / LD

Signature of Vaccine Administer: _____RN