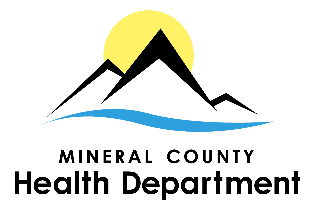
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**Consent for Services & Billing**

**Complete form at each visit:**

**Patient Information**

|  |  |
| --- | --- |
| **Patient’s Legal Name:** | **Patient Date of Birth:** |
| **Date of Service:** | |
| **Allergies:** | |
| **Current Medications:** | |

**Acknowledgement and Consent**

|  |  |
| --- | --- |
|  | **Initials** |
| I am requesting vaccination services for myself and/or the persons identified, of whom I am authorized to sign. A copy of the appropriate Centers for Disease Control and Prevention Vaccine Information Statement(s) has been provided. I have read the information about the disease(s) and the vaccine(s) listed. I believe that I understand the benefits and risks of the vaccine(s) cited and ask that the vaccine(s) listed be given to me or to the person named (for whom I am authorized to make this request). |  |
| I have received, if requested, the Notice of Privacy Practices (HIPAA,) which provides a description of information, uses and disclosures. |  |
| I authorize this health care provider and a public health agency to collect and enter immunization records into the Department of Public Health and Human Services’ Immunization Information System (IIS). The IIS is a confidential, computer system that contains immunization records. I understand that information in the registry may be released to a public health agency as well as my or my child's health care providers to assist in medical care and treatment. In addition, information may be released to child care facilities or schools in order to comply with immunization requirements. I understand that I can revoke this authorization and have my or my child's record removed at any time by contacting the State of Montana Immunization Program. |  |
| I authorize payment of medical benefits to this county health department for services rendered. I understand that the patient/parent or responsible party is responsible for any unpaid balances |  |
| I understand that it is recommended that the patient wait at the vaccine administration location for 15 minutes after receiving vaccine(s.) |  |

**Patient/Parent Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Health Screening Questionnaire**

The following questions will help us determine which vaccines you or 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 will be asked. If a question is not clear, please ask your healthcare provider for explanation.

**Answer all questions**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **Yes** | **No** | **Don’t Know** |
| 1. | Is the patient sick today or have had an illness with a fever within the last 24 hours? |  |  |  |
| 2. | Does the patient have allergies to medications, food, a vaccine component or latex? |  |  |  |
|  | * Chicken eggs (anaphylactic reaction, hives, swelling of mouth and throat, difficulty breathing) |  |  |  |
|  | * Yeast (anaphylactic reaction, hives, swelling of mouth and throat, difficulty breathing) |  |  |  |
|  | * Gelatin |  |  |  |
|  | * Streptomycin, Neomycin or Polymixin B |  |  |  |
|  | * Latex |  |  |  |
|  | * Thimerisol |  |  |  |
| 3. | Has the patient had a serious reaction to a vaccine in the past? |  |  |  |
| 4. | Does the patient 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? |  |  |  |
| 5. | If the patient 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? |  |  |  |
| 6. | If the patient is a baby, have you ever been told he or she has had intussusception? |  |  |  |
| 7. | Has the patient, a sibling, or a parent had a seizure; has the patient had brain or other nervous system problems? |  |  |  |
| 8. | Does the patient have cancer, leukemia, HIV/AIDS or any other immune system problem? |  |  |  |
| 9. | Does the patient have a parent, brother or sister with an immune system problem? |  |  |  |
| 10. | In the past 3 months, has the patient 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? |  |  |  |
| 11. | In the past year, has the patient received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? |  |  |  |
| 12. | Is the patient pregnant or is there a chance she could become pregnant during the next month? |  |  |  |
| 13. | Has the patient received vaccinations in the past 30 days? |  |  |  |
| 14. | Has the patient taken any antiviral medication 24-48 hours before vaccination? |  |  |  |
| 15. | Has the patient ever had Guillan-Barre Syndrome? |  |  |  |



**Patient/Parent Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Form Reviewed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**