South Central Public Health District
Prevent. Promote. Protect.

Twin Falls – 208.737.5980
Heyburn – 208.678.8221
Jerome – 208.324.8838
Gooding – 208.934.4477
Bellevue – 208.788.4335

INFLUENZA IMMUNIZATION REGISRATION FORM – PLEASE PRINT

Patient Last Name	Patient First Name	Date of Birth	□ Male □ Female
Mailing Address	City	State	Zip Code
Parent/Guardian Name	Parent/Guardian Date of Birth	Phone Number	
Does the Patient have Insurance? □ YES □ NO	Name of Insurance Company	Identification Number	

Race: □ White □ Black or African American □ American Indian or Alaska Native □ Asian □ Native Hawaiian or Other Pacific Islander □ Other □ Decline to Specify	**Ethnicity:** □ Non-Hispanic □ Hispanic/Latino □ Other □ Decline to Specify	**NOTE: Without insurance information you will be billed directly for your vaccines. If you are uninsured contact our office. For Tricare use the benefit number from the back of the card.** Children ≤18yrs will not be denied vaccines due to inability to pay.

For parents and guardians: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask a staff member to explain it.

		YES	NO	N/A
1.	Is the person to be vaccinated sick today?	□	□	□
2.	Does the person to be vaccinated have an allergy to an ingredient of the influenza vaccine?	□	□	□
3.	Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	□	□	□
4.	Is the person to be vaccinated younger than age 2 years or older than age 49 years?	□	□	□
5.	Does the person to be vaccinated have a long-term health problem with lung disease (including asthma), heart disease, kidney disease, neurologic disease, liver disease or metabolic disease (e.g., diabetes)?	□	□	□
6.	**For children only**: 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?	□	□	□
7.	Does the person to be vaccinated have a) an open channel between the cerebrospinal fluid (CSF) and the mouth, throat, nose or ear or any other cranial CSF leak, or b) a cochlear implant, or c) an immunocompromising condition due to any cause (e.g., medication, congenital or acquired immunodeficiency, HIV infection, or a missing or non-functioning spleen [e.g., caused by sickle cell disease])?	□	□	□
8.	Is the person to be vaccinated currently taking influenza antiviral medications, or have they taken any within the past 3 weeks?	□	□	□
9.	Is the person to be vaccinated a child or teen age 6 months through 17 years and receiving aspirin or salicylate-containing medicine?	□	□	□
10.	Is the person to be vaccinated pregnant or could they become pregnant within the next months?	□	□	□
11.	Has the person to be vaccinated ever had Guillain-Barré syndrome?	□	□	□
12.	Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (e.g., an isolation room of a bone marrow transplant unit)?	□	□	□
13.	Has the person to be vaccinated received any other vaccinations in the past 4 weeks?	□	□	□

SIGN CONSENT on next page →

MEDICAL SERVICES CONSENT

- I have been offered copies (electronic and/or paper) of the Vaccine Information Statements (VIS) for all vaccines being given today.

Live, Intranasal Influenza Vaccine
(age 2 to 49 yrs old)
https://www.cdc.gov/vaccines/hcp/vis/vis-statements/flulive.pdf

Inactivated Influenza Vaccine
(age 6 months and older)
https://www.cdc.gov/vaccines/hcp/vis/vis-statements/flu.html

- I understand the benefits, risks, or potential side effects from vaccines.
- I understand that all immunization records will be entered into Idaho IRIS (Immunization Reminder Information System) registry. Participation in the immunization registry is voluntary. To have your records removed from IRIS, you must contact the Idaho Immunization Program. https://healthandwelfare.idaho.gov/services-programs/children-families/about-immunizations
- I understand that vaccines are not mandatory. Per IC 39-4802 parents may submit exemptions for immunizations in lieu of immunization records to the school district in which they are or wish to enroll in.
- I have been offered a copy of SCHPD's Notice of Privacy Practices.
- I consent to receive vaccinations provided by SCPHD for myself or for the child for whom I am the parent or legal guardian.

FINANCIAL CONSENT

- SCPHD will bill your insurance company for you, and the payment may come directly to SCPHD.
- SCPHD may not be considered an In-Network provider and therefore cannot guarantee coverage by your insurance company.
- Whether your insurance company pays or not, your account balance is your responsibility.
- Some, or perhaps all, of the services provided may be non-covered services.
- Confidentiality cannot be guaranteed with insurance billing. Your insurance provider may send information to the holder of the insurance policy (who may be your parent, guardian or spouse).

I have read the Medical Services and Financial Consent. I understand and agree to this policy. I also understand that I will be responsible for payment of all services. I authorize release of medical information necessary to process medical claims and authorize payment of benefits to SCPHD.

Parent/Guardian Signature: _____ Date: _____

FOR OFFICE USE ONLY

Vaccine	Site	Lot #	Vaccine	Site	Lot #

Nurse Signature: _____ Date: _____

CSR Name: _____ School/Location: _____