Lenawee County HEALTH DEPARTMENT
We're Here for You

Patient # | Encounter #

ADULT IMMUNIZATIONS

CLIENT REGISTRATION FORM
LENAWEE COUNTY HEALTH DEPARTMENT
1040 S WINTER ST., SUITE 2328
ADRIAN, MI 49221

_____/_____/_____
Date of Birth

_____
age

PLEASE PRINT CLIENT NAME

_____~_____~_____
FIRST *MIDDLE* *LAST*

_____
Street Address *City* *State* *ZIP*

_____
EMAIL ADDRESS

_____
Guardian's Name (if applicable) - please print

PRIMARY LANGUAGE (circle one): ***ENGLISH*** ***OTHER*** _____

☐ **MALE**

☐ **FEMALE**

RACE *(check one)*
☐ Asian/Pacific ☐ White
☐ Multiracial ☐ Unknown
☐ Hawaiian/Pacific
☐ Black or African American

ETHNICITY
(circle one)

Hispanic

Non-Hispanic

Client Home Phone Number
( ) _____ - _____

Client Cell Phone Number
( ) _____ - _____

Private Physician Name:

_____

Screening Questions

1.	Is the client sick today?	YES	NO
2.	Does the client have any allergies to medications, eggs, latex, Mercury, Thimerosol, or any vaccine? If **YES**, please list on the back of this form.	YES	NO
3.	Has the client had a **SERIOUS REACTION** to a vaccine in the past?	YES	NO
4.	Does the client have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?	YES	NO
5.	Does the client have cancer, leukemia, AIDS or any other immune system problem?	YES	NO
6.	Has the client taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs or drugs for the treatment of arthritis, Crohn's disease, or psoriasis or had radiation treatments in the past 3 months?	YES	NO
7.	Has the client had a seizure, a brain, or other nervous system problem?	YES	NO
8.	Has the client received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug during the past year?	YES	NO
9.	Women: Is the client pregnant or is there a chance you could become pregnant during the next month?	YES	NO
10.	Has the client received any vaccinations in the past 4 weeks?	YES	NO

I authorize the Lenawee County Health Department to release to my insurance information needed for this claim and payment of medical insurance benefits. If my health insurance company denies payment, I agree to be responsible for payment. I also understand that if my health insurance company does make payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies.

_____ _____/_____/_____
Signature of client/parent/guardian **DATE**

FOR OFFICE USE ONLY

MI VRP		
☐ NO medical insurance	☐ Health insurance that does NOT cover immunizations	☐ Medicaid
☐ Private Insurance	☐ Self-Pay	☐

Vaccine Grant # _____ Patient pay # _____ Write off # _____

PLEASE LIST ALL ALLERGIES.
(screening question 2)

_____

_____

_____

_____

Nursing notes:

_____

_____

_____

_____