Lenawee County HEALTH DEPARTMENT
We're Here for You

Patient # | Encounter #

PEDIATRIC IMMUNIZATIONS

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

Client: Weight: _____

_____/_____/_____
Date of Birth

_____
Child's age

PLEASE PRINT CLIENT NAME

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

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

_____
EMAIL ADDRESS

_____
PLEASE PRINT NAME OF: Parent Guardian Grandparent Other (circle one)

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 child sick today?	YES	NO
2.	Does the child 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 child had a **SERIOUS REACTION** to a vaccine in the past?	YES	NO
4.	Has the child had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder or is he/she on long-term aspirin therapy?	YES	NO
5.	For children 2 through 4 years of age, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	YES	NO
6.	For babies, has a healthcare provider ever told you that the child has had intussusception?	YES	NO
7.	Has the child, a sibling, or a parent had a seizure or has the child had a brain or other nervous system problems?	YES	NO
8.	Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?	YES	NO
9.	In the past 3 months, has the child taken medications that affect the immune system such as prednisone, other steroids, anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?	YES	NO
10.	In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or antiviral drug?	YES	NO
11.	For females is the child/teen pregnant or is there a chance she could become pregnant during the next month?	YES	NO
12.	Has the child received 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

VFC/EXPANDED ELIGIBILITY SCREENING STATEMENT
(the person receiving these immunizations is:)

☐ has health insurance that does NOT cover immunizations	☐ *is an American Indian or Alaskan native*	☐ *is covered by PRIVATE insurance (other than Medicaid) that covers all or part of the cost of immunizations*
☐ is enrolled in MEDICAID	☐ *does NOT have medical insurance*	☐ *has exceed annual cap on preventative care*

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

PLEASE LIST ALL ALLERGIES.
(screening question 2)

_____

_____

_____

_____

Nursing notes:

_____

_____

_____

_____