



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, Thimerosal, or any vaccine? If <b>YES</b> , please list on the back of this form.  | YES NO |
| 3. Has the child had a <b>SERIOUS REACTION</b> 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:)

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

Vaccine Grant # \_\_\_\_\_ Patient pay # \_\_\_\_\_ Write off # \_\_\_\_\_

**PLEASE LIST ALL ALLERGIES.**  
(screening question 2)

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Nursing notes:

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