CASPER-NATRONA
COUNTY HEALTH DEPARTMENT

CHILD & ADOLESCENT IMMUNIZATION CONSENT & ADMINISTRATION FORM

PATIENT INFORMATION:

Last Name: _____ First Name: _____ Middle Initial: ___ WY Resident: Yes or No

Mailing Address: _____ City/State/ZipCode: _____

Primary Phone #: _____ Date of Birth: _____ Age: _____

Gender Identity: ☐Male ☐Female ☐Other _____

EMPLOYER RESPONSIBILITY: Yes or No If "Yes", Employer Name: _____

INSURANCE STATUS: ☐ Uninsured ☐ Underinsured
☐ Insured (billing insurance) ☐ Insured (choosing not to bill insurance, paying out of pocket) ☐ Medicaid

Complete the following *if* billing insurance

Medicaid# *or* Social Security#: _____

Insurance Name:_____ **Insurance Number:**_____

Group Number: _____ **Policy Holder Name:**_____

Policy Holder Date of Birth:_____ **Policy Holder Address:** _____

SCREENING QUESTIONAIRE

Are you ill today?	Yes	or	No
Have you ever had a severe allergic reaction (anaphylaxis) to a vaccine in the past?	Yes	or	No
Do you have severe allergic reactions to latex or yeast?	Yes	or	No
Do you have a history of Guillain-Barre Syndrome (a paralysis problem)?	Yes	or	No
Do you have any medical conditions or take any medications that make you severely immunocompromised?	Yes	or	No
Do you have a history of intussusception (a rare condition causing telescoping of intestines)?	Yes	or	No
Have you ever received a flu vaccine?	Yes	or	No
In the past 4 weeks, have you received any live vaccines such as MMR, Varicella (chickenpox), Yellow Fever, or Flu Mist?	Yes	or	No
Have you ever had chickenpox disease?	Yes	or	No
FEMALES ONLY: Are you pregnant or is there a chance you could become pregnant within the next 4 weeks?	Yes	or	No

I have been offered the Vaccine Information Statement about the vaccine(s) to be given today. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) and ask that the vaccine(s) be given to me or the patient named above for whom I am authorized to make this request as their legal guardian.

The Notice of Privacy Practices describes how CNCHD may use or disclose information. Not all situations may be described. CNCHD is required to offer its clients a Notice of Privacy Practices pertaining to information we use, maintain, and disclose. I have been presented with a copy of the CNCHD Notice of Privacy Practices. I have had the chance to ask questions that were answered to my satisfaction about how my information will be used.

I, HEREBY, ATTEST THAT THE INFORMATION GIVEN ABOVE IS ACCURATE/TRUE, AND I AGREE TO THE TERMS AND CONDITIONS AS SET FORTH ABOVE.

_____ _____
Printed Name of Legal Guardian Relationship to Patient

_____ _____
Signature of Legal Guardian (Patient Signature if 18 or older) Date of Signature

----------FOR CLINIC STAFF USE ONLY----------

DATE	VACCINE	LOT#	SITE/ROUTE	PUB / PRVT	VFC ELIGIBLE?	NURSE SIGNATURE
					YES NO	
					YES NO	
					YES NO	
					YES NO	
					YES NO	
					YES NO	
					YES NO	

REVISED: 9/16/2020